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ABSTRACT

These training materials derive from a personnel preparation special project that developed, implemented, and evaluated a teaching model on collaborations necessary for effective delivery of early intervention. Module 1 provides an overview of the history of early intervention and the legal statutes that define early intervention. Module 2 describes ways in which agencies can share the responsibilities of providing services to the same audience, offers strategies for overcoming barriers, and discusses the process of building collaborative relationships. Module 3 introduces the concept of family-centered care as the foundation necessary for any collaborative relationship that provides service to children and describes the leading role the family plays in the development of the Individualized Family Service Plan. Module 4 discusses ways that early intervention service providers can work with the family to develop an early intervention program. This module covers the factors that affect the development and maintenance of the team, as well as strategies for overcoming barriers to the team process. The last module presents the service provider with the tools necessary to participate in a collaborative early intervention service delivery system. Specifically, the module focuses on the importance of communication, trust building, and negotiation. (CR)

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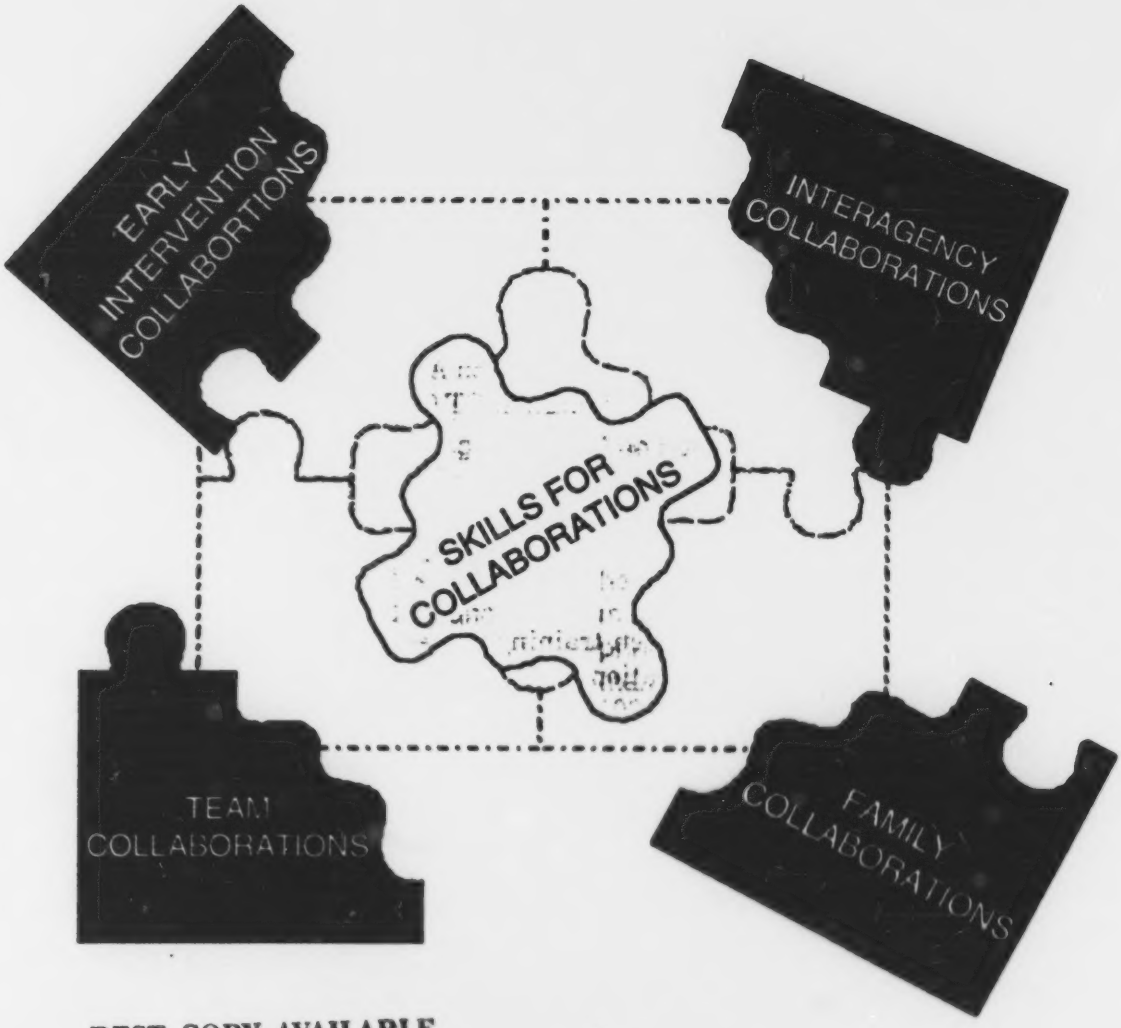
Collaboration: Putting the Puzzle Pieces Together



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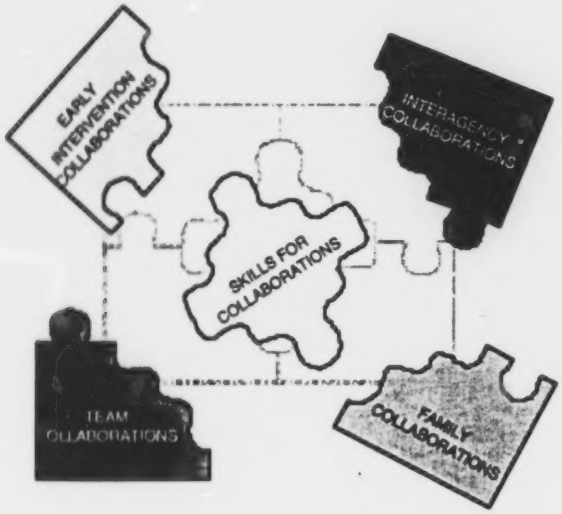


INTRODUCTION

Collaboration is a challenging, yet important goal for the field of early intervention. As the number of children who are eligible for early intervention grows, it is imperative that service providers and agencies learn to work together to maximize the available resources for service delivery.

The purpose of this manual is to highlight the important aspects of the collaborative process for early intervention. The analogy of a puzzle has been used in the layout of the manual because the underlying principles as presented in each of the manual's modules are essential for successful early intervention collaborations.

Module One: Early Intervention Collaborations

provides an overview of the history of early intervention and the legal statutes that define early intervention. Within these statutes, are the program requirements that underscore the importance of collaboration in early intervention services and the coordination that must accompany services delivered by multiple agencies.

Module Two: Interagency Collaborations

describes the ways in which agencies can share the responsibilities of providing services to the same audience. The module acknowledges the barriers to the collaborative process, offers some strategies for overcoming these barriers, and discusses the process of building collaborative relationships.

Module Three: Family Collaborations

introduces the concept of family-centered care as the foundation necessary for any collaborative relationship that provides services to children. Through the framework of the Individualized Family Service Plan (IFSP), legislators mandated that services be available to infants and toddlers and their families. The family-centered IFSP ensures that appropriate services are available to the infant or toddler and his or her family members by acknowledging the leading role the family plays in the IFSP process.

Module Four: Team Collaborations

discusses the different ways early intervention service providers can work together with the family to provide an early intervention program for the child. The effectiveness of the program strongly relies on the abilities of the service providers and family members to function as a team. This module covers the factors that affect the development and maintenance of the team, as well as strategies for overcoming barriers to the team process.

Module Five: Skills for Collaborations

presents the service provider with the tools necessary to participate in a collaborative early intervention service delivery system. Specifically, the module focuses on the importance of communication, trust building, and negotiation.

Collaborations must occur among families, service providers, and agencies. To help illustrate the key concepts of the collaborative process, the manual presents a family story of a little girl, Polly, who receives early intervention services. At the end of each module, you will be asked to apply the concepts to Polly's service delivery program. These activities are designed to demonstrate the effort that a collaborative relationship requires, as well as the difference a collaborative relationship can make to a family and child.

Polly's Story

Polly is 18 months old and lives with her family in central Connecticut. She was born prematurely at a tertiary care hospital, the sole survivor of a set of triplets. Polly was hospitalized for 13 months following birth. Her medical and developmental conditions include:

- Brain damage that resulted from spinal meningitis
- Hydrocephalus, an enlargement of the head due to a buildup of fluid within the brain (A shunt has been surgically inserted to drain excess fluid from the cranial area.)
- Episodes of congestive heart failure
- Frequent infections that result in hospitalization
- A dependency on oxygen
- Self-abusive episodes, including severe head banging

As a result of these conditions, Polly and her family have been receiving a variety of services since she has been home, including:

- Health care through her primary pediatrician
- Occupational therapy once a week
- Speech therapy once every other week
- Physical therapy once a week
- Home education through a regional education service center (RESC) twice a week
- Sixteen hours per day of home nursing care
- Medical supply vendors for special formulas and oxygen
- Specialty care at a variety of clinics at the tertiary care hospital

Numerous professionals visit Polly and her family at their home on a regular basis. During the five months that Polly has been home, she has received services from five therapists, two teachers, ten nurses, and a hospital-based team composed of a physician, two nurses, a psychologist, a full range of therapists, and a social worker. Also assigned to her "case" are two social workers, three program supervisors, and three service coordinators from three separate agencies.

It is not surprising that Polly's parents are often caught in the middle of conflicts among the various professionals, each of whom seems to have a different opinion about Polly's needs, appropriate treatments, payment options, and service schedule. For example, the family has three case managers. Each manager gave the family different information about eligibility for various public sources of funding, including the Medicaid waiver. As a result, the family's application for benefits was delayed and they had to pay several thousand dollars out-of-pocket for Polly's cost of care. Additionally, the nursing agency and the various therapists disagree about the amount of therapy Polly needs, resulting in a lack of cooperation between the agency and therapists. Consequently, Polly's parents feel that the services she receives often cause confusion in their lives. The schedule for a typical week in their house looks like this:

Monday:	16 hours	-	nursing, teacher, supervisor, Department of Income Maintenance (DIM) case manager
Tuesday:	16 hours	-	nursing, occupational therapy, Department of Mental Retardation case manager
Wednesday:	16 hours	-	nursing, teacher, clinic visit at tertiary hospital, physical therapy
Thursday:	16 hours	-	nursing, physical therapy, vendor delivery, nursing supervisor, teacher
Friday:	16 hours	-	nursing, speech therapy, adaptive equipment fitting at tertiary care hospital
Saturday:	16 hours	-	nursing
Sunday:	16 hours	-	nursing

Polly's parents have concluded that caring for her is not the primary cause of their stress. Instead, they attribute it to the multiple layers of fragmented services that has created so much havoc within their family. They are now seeking out-of-home placement for Polly because they feel that they need to restore order back into their lives. Neither feels "functional" with so many people in and out of their home. In Polly's case, one of the purposes of P.L. 99-457 (to reduce the likelihood of institutionalization) has not been realized.

Helping Polly Through Collaboration

Polly is typical of many infants and toddlers who have multiple disabilities. The parents of these children usually interact with a variety of agencies and programs in order to meet the unique intervention needs of their child. Unfortunately, when trying to gain access to these services, parents are often confronted with a multitude of incomprehensible acronyms and an unwieldy maze of agencies that differ in priorities, mandates, geographic boundaries, and administrative structures.

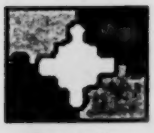
The needs of infants and toddlers with disabilities have also created many challenges for service

providers. Both federal legislation and recommended practice mandate that early intervention programs be family-centered, comprehensive, community-based and coordinated. State and local service agencies are presently struggling to develop such programs.

Most often, early intervention programs for infants and toddlers with disabilities consist simply of those services that are readily available. While the program may meet the needs of some families, other families may require a number of additional services that may be more difficult to access. This is especially true for those families who have children with multiple needs. For example, Polly's needs require her to participate in a hospital follow-up clinic, hospital- and home-based therapy, home health services (including equipment maintenance), and intervention program services from three agencies. These services are all limited in the type, frequency, and location of their delivery, and this dictates the options (or lack thereof) available to Polly's family. Additionally, the agencies providing the services have different goals, orientations, funding sources, and continuing eligibility requirements that further limit the availability of services.

Although it is clear that few agencies have the resources to provide a continuum of services to deal with all of the issues that may affect an infant or toddler with disabilities and his or her family, services must be restructured in such a way as to maximize coordination and enhance, rather than inhibit, family functioning.

When examining the unique services required by Polly and her family, the immediate challenge is to identify the various agencies, professionals, and payment sources currently involved in the provision of early intervention services in the community. While interagency and multidisciplinary coordination may be the first step toward alleviating some of the stress that Polly's family experiences, the ultimate goal should be the collaborative development of an individualized family service plan (IFSP) to be carried out under the direction of the family. There are two keys to this goal: family-centered services and collaborative service delivery. The purpose of this manual is to discuss the collaborative relationships required by Part H of IDEA, and, in particular, the family-centered and multidisciplinary interagency aspects of service provision.



Early childhood is an important time in any person's life. For children with disabilities, the early years are critical for a number of reasons. First, the earlier a child is identified as having a developmental delay or disability, the greater the likelihood that the child will benefit from intervention strategies. Second, families benefit from the support given to them through the intervention process. Third, schools and communities benefit from a decrease in costs because more children come to school ready to learn.

As a field, early intervention has been defined as the provision of educational or therapeutic services to children under the age of eight. Legislatively, "early intervention" is used to describe the years birth to three, while the term "early childhood special education" or "preschool special education" refers to the period of preschool years (ages three through five). This manual will use the term "early intervention" as a description of services provided to children from birth to age three under the Individuals with Disabilities Education Act, Part H.

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Historical Perspective on Early Intervention

The history of early intervention spans multiple disciplines and fields of study. For example, the child development literature has provided early intervention a theoretical focus that has evolved from the transactional model of development. At one time, child development theory was polarized into two competing schools of thought: a biologically based view of development versus one that stressed behavioral and environmental factors. The transactional developmental theory represents a synthesis of the two theories: it emphasizes the interactive nature of child development.

The transactional model of development recognizes the fact that the interaction between the child and the environment is a continual process in which neither the child's status, nor the environmental effects on that status can be separately addressed. This developmental model suggests that the environment can be used to modify a child's biological limitations, and conversely, a deficient environment can lead to delays in a child's development. This focus has greatly influenced both early intervention strategies and early intervention service models, most notably on the emphasis placed on a child's relationship with his or her caregiver.

The maternal and child health field has emphasized the role of government in designing and supporting practices to promote the well being of children. The Children's Bureau, which was established by Congress in 1912, collected data on such issues as institutional care, mental retardation, and the care of crippled children. These data resulted in the funding of a national network of Maternal and Child Health centers and an increase in public health nursing.

In 1930, the White House Conference on Child Health and Protection recommended that programs for crippled children be made available in each state. The Social Security Act, enacted in 1935, established Maternal and Child Health Services, as well as services for "crippled children." Lastly, the Social Security Act amendments in 1965 included Medicaid services for children. In particular, the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program was initiated for all children under age 21 who qualified for Medicaid. EPSDT was funded to assist in the early identification and treatment of children's health and developmental needs.

Activity 1.1

List the agencies in your state that utilize MCH funds.

The field of early childhood education was also an important contributor to current early intervention service models. Initially, early childhood programs were developed to serve poor children and the parents of poor children. The concept of kindergarten was established in the early 1800's by proponents such as Friedrich Froebel in Germany, who emphasized the importance of play and learning for young children. The first public school kindergarten program was established in the United States in 1872. At the turn of the century, half of all kindergartens in the U.S. were operated by public school systems, although the major focus was on the potential benefits of such programs for children who were poor.

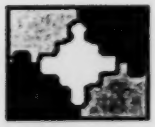
The concept of preschool or nursery school was firmly established in the early 1900's, and, as with kindergarten, the concept was developed in Europe. In England, the MacMillan sisters began nursery schools to provide for the emotional and physical well-being of poor

children. Their focus was on the development of self care, responsibility, and educational readiness skills. In Rome, Maria Montessori also established early education programs for poor children. She had initially worked with children who were mentally retarded and used educational practices that emphasized learning through active involvement with the environment.

In the United States, both the Depression and World War II resulted in the government providing assistance to expand early education (both day programs and kindergarten) opportunities for young children, primarily as a support for working mothers. However, between 1946 and the Kennedy Administration (1960-63), early childhood programs remained stagnant. President Kennedy expanded the nation's commitment to early care by supporting legislation and appropriations to assist working mothers.

The largest government funded early childhood program, Head Start, was established in 1965. Head Start began as a compensatory program for four-year-old and five-year-old children from low income families. The program provided comprehensive early childhood services focusing on health, education, social services, and parent involvement. Other compensatory programs for young children were funded by a variety of legislative initiatives, many of which remain in effect today. For example, the Community Coordinated Child Care Program was established to improve all early childhood programs financed by federal funds. Unfortunately, this effort was inadequately funded, but it represented an initial attempt by the federal government to coordinate federal initiatives for young children.

Most recently, the federal Family Support Act (1988) and the Child Care and Development Block Grant (1991) recognized the importance of early care and education programs. States are authorized to coordinate such programs to ensure accessibility by families in need of child care, Head Start, and other children's services. Rather than draw a distinction between nursery school, compensatory programs, and child care, proponents have recently recommended the development of integrated systems of early care and education. However, fragmentation of services and dwindling resources continue to hamper efforts to build capacity and to enhance the quality of early childhood education so that all children may benefit from such programs.



Activity 1.2

List agencies in your state that receive either Head Start or Child Care and Development Block Grant funds.

Lastly, the field of special education contributed to the development of early intervention through its emphasis on remedial and compensatory services and instructional techniques. Special education history began in the late 1700's in France with the story of Victor, a child who had grown up with wolves. Jean-Marc Itard developed and provided an intensive education program to teach Victor (who was known as the "Wild Boy of Aveyron") language and behavior skills. His success led a student of his, Edourd Sequin, to develop a physiological method to educate children with disabilities. This method emphasized the importance of early education and the use of detailed assessment information from which to develop a remediation plan. Unfortunately, the techniques used by Itard and Sequin were not universally adopted, and the preferred treatment for people with disabilities during the 1800's in both Europe and the United States was institutionalization and segregation from society.

People with disabilities received more benevolent attention after World War II, partly because of the number of injured veterans who returned home with rehabilitation needs. A Section for Exceptional Children was established within the U.S. Office of Education in 1946. As rehabilitation services became more plentiful, parents of children with disabilities organized into advocacy groups to increase the availability of services to their children. Many advocacy organizations became developers and providers of preschool services.

During the Kennedy Administration (1960-1963), the government became more involved in providing services to children with disabilities. This commitment was formalized by Congress in 1966 when the Section for Exceptional Children was expanded to the Bureau of Education for the Handicapped within the U.S. Office of Education. A number of legislative initiatives also began in this era, including the 1968 Handicapped Children's Early Education Assistance Act. The act provided federal funds to support model demonstration programs to educate infants and preschool-age children with disabilities. This impetus began to raise awareness about the importance of early intervention and an early childhood branch was developed in the Office of Special Education and Rehabilitation Services within the U.S. Department of Education. It was not until 1986 however that a federal mandate was established to make special education services available to all preschool-age eligible children with disabilities. This mandate was established as P.L. 99-457, a set of amendments to P.L. 94-142, the Education of All Handicapped Children Act (later renamed the Individuals with Disabilities Education Act, or IDEA).

IDEA mandated a free appropriate public education to all school-age children with disabilities. P.L. 99-457 then added to IDEA a number of significant components specific to children under age five. First, services for eligible young children (ages three through five) were mandated under the provisions of free appropriate public education (Part B of P.L. 94-142). Second, these amendments created incentives for states to develop an early intervention entitlement program for children from birth through age two (Part H). Through IDEA's Part H, Congress identified an "urgent and substantial need" to enhance the development of infants and toddlers with disabilities, to minimize the likelihood of institutionalization and the need of special education services after this group reaches

school age, and to enhance the capacity of families to meet the special needs of their infants and toddlers with handicaps (Education of the Handicapped Act Amendments of 1986, Section 671). To meet this need, federal financial help was made available to the states to develop programs to deliver interagency, multidisciplinary services for all eligible children. Table 1-1 contains a listing of the system components each state had to have in place in order to qualify for Part H federal funds. As of 1995, all U.S. states and territories were participating in Part H services.

Table 1-1: Early Intervention System Components

1. A state definition of the term "developmental delay."
2. A timetable to ensure services.
3. A multidisciplinary evaluation of each eligible child.
4. An IFSP, including service coordination, for each eligible child and family.
5. A comprehensive child find campaign.
6. A public awareness system.
7. A central directory of services and other resources.
8. A comprehensive program of personnel development.
9. Designation of a single line of responsibility in the lead agency.
10. A policy on contracting with local service providers.
11. Procedures for timely reimbursement of funds.
12. Procedural safeguards.
13. Policies for personnel standards.
14. A system for compiling data.

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Activity 1.3

Describe how each of the 14 components are being implemented in your state.

COMPONENTS	IMPLEMENTATION STATUS
1. A state definition of the term "developmental delay."	
2. A timetable to ensure services.	
3. A multidisciplinary evaluation of each eligible child.	
4. An IFSP, including service coordination, for each eligible child and family.	
5. A comprehensive child find campaign.	
6. A public awareness system.	
7. A central directory of services and other resources.	
8. A comprehensive program of personnel development.	
9. Designation of a single line of responsibility in the lead agency.	
10. A policy on contracting with local service providers.	
11. Procedures for timely reimbursement of funds.	
12. Procedural safeguards.	
13. Policies for personnel standards.	
14. A system for compiling data.	

Program Requirements

Part H of IDEA recognized the fact that no single agency or service provider has all of the knowledge and skills necessary to meet the multiple needs of families participating in early intervention. Many of the provisions of the law require both coordination and collaboration at the local, state, and federal levels. For example, states that are participating in the federal program must initiate a number of collaborative planning and implementation activities. Among these are:

- ***The establishment of a statewide interagency coordinating council (ICC) composed of parents and representatives from relevant state agencies and service providers.***

  The reauthorization of P.L. 99-457 requires that these councils consist of between 15 and 25 members and that the chair *not* be from the lead agency. Councils may vary in how many agencies are represented; at least 20% of the membership must be parents however.

- ***The maintenance of a lead agency for general administration, supervision, and monitoring of programs and activities, including responsibility for carrying out the entry into formal interagency agreements and the resolution of disputes.***

  Approximately 21 states have chosen the Department of Education as their lead agency; others have chosen their Department of Health or Department of Developmental Disabilities or Mental Retardation.

- ***The development of interagency and multidisciplinary models of service delivery for eligible infants, toddlers, and their families as specified in the IFSP, which is directed by the family.***

  "Multidisciplinary" has been further defined by the U.S. Department of Education to mean efforts involving persons representing at least two professional disciplines.

- ***The appointment of a service coordinator to facilitate and ensure the implementation of the IFSP.***

  The service coordinator is responsible for the implementation of the IFSP and for ongoing coordination with other agencies and individuals to ensure the timely and effective delivery of services. Part H of

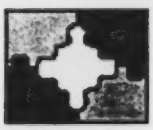
IDEA does not designate any single professional to assume this role. In fact, the recent reauthorization acknowledges the rights of family members to fill this role (for themselves or others), if they obtain "appropriate training." The legislation defines the duties of the service coordinator as follows:

to assist and enable an eligible child and the child's family to receive the rights, procedural safeguards, and services that are authorized under the state's early intervention program. Service coordinators are responsible for coordinating all services across agency lines and serving as the single point of contact in helping parents to obtain the services and assistance they need (34 CFR §303.22).

Activity 1.4

Which of the four collaborative activities described above seems to be the most challenging to you? Why?

Which of the collaborative activities seems to be the easiest? Why?



Background on Service Coordination

The recognition of the need for service coordination stems from previous experience in social work and nursing. Professionals in these fields often worked in the capacity of managing a number of agency representatives that had an impact on the day-to-day functioning of people with developmental disabilities, mental illness, or complex medical needs. As a result, social workers and nurses may receive more training than others in the competencies necessary for service coordination. The demands of the early intervention system, however, require that members of each discipline involved in service delivery receive adequate preparation to fulfill both the spirit and intent of the law.

The regulations of Part H of IDEA do not establish discipline-specific requirements for service coordinators. Rather, the general qualifications are the knowledge of:

- early intervention legislation on state and federal levels.
- infants and toddlers with disabilities.
- available resources.
- procedural safeguards available to families.

The role of service coordinator is critical to the implementation of the family-centered philosophy of the law. Rather than act on behalf of families, or as a restraint on optimal service provision, the service coordinator must facilitate the true intent of the law: to support families in their caregiving role. Service coordination must occur within a collaborative problem-solving partnership between the coordinator and the family. The overall process includes the following activities:

(1) coordinating the performance of evaluations and assessments; (2) facilitating and participating in the development, review, and evaluation of IFSPs; (3) assisting families in identifying available service providers; (4) coordinating and monitoring the delivery of available services; (5) informing families of the availability of advocacy services; (6) coordinating with medical and health providers; and (7) facilitating the development of a transition plan to preschool services, if appropriate.

In a coordinated system, the family and child actively participate in a productive and constructive process that views the infant or toddler from his or her family's perspective; this is the ultimate goal of effective service coordination and collaborative service delivery. For this reason, service coordinators must have excellent interpersonal, communication, negotiation, and facilitation skills.

Activity 1.5

What steps/actions could a service coordinator take to make sure family-centered, comprehensive, coordinated services are being delivered?

Inherent in these provisions is the concept of a statewide system of coordinated, comprehensive, multidisciplinary, interagency programs of early intervention services for infants and toddlers with disabilities and their families. This concept requires commitment by all service agencies and providers to cooperatively and collaboratively plan, implement, and evaluate services that enhance the capacity of families to meet the special needs of their children. Clearly, the challenge to the service delivery system is to develop new interagency and multidisciplinary models of early intervention that meet the intent of the law, and, most importantly, the needs of families such as Polly's.

Activity 1.6

Now think about Polly's story. Does her service delivery plan meet the intent of the laws governing early intervention?

Specifically state the aspects of her service delivery that are not compliant.

Notes

Collaboration is a term used to describe efforts to unite people, professionals, programs, or agencies for the purpose of achieving common goals that could not be accomplished by an agency or individual working alone. Infants and toddlers with disabilities and their families have needs that are diverse, interrelated, and vary over time. No single agency or service provider has all of the skills necessary to meet the needs of a child with disabilities and his or her family. Service agencies and providers must work together to plan, implement, and evaluate services that enhance a family's ability to meet the special needs of the child.

In order to do this, collaborations must occur within all levels of service delivery, beginning at the agency level.

There are three ways agencies and service providers can come together to serve young children with disabilities: they can ***cooperate, coordinate, and collaborate***.

Cooperation

Cooperation is the first step in developing an effective service delivery system. It is characterized by people, programs, and agencies informally sharing information

(e.g., brochures, mailing lists, newsletters, and trainings) to achieve day-to-day goals. Cooperation does not require groups to be interdependent or interactive in terms of their formal policies, procedures, or activities. For example, an early intervention service provider cooperates with family members by sharing information with them regarding their child's disability, the child's specific developmental needs, and the services available to meet those needs.

Coordination

When people begin to realize that they share similar responsibilities, they are ready to take the next step toward effective service delivery: coordination. Coordination is characterized by people, programs, and agencies formally defining their roles and responsibilities. This can result in the elimination of any gaps or duplication in the service delivery system. Like cooperation, coordination requires agencies to share information and resources, but on a more formal level. For example, as groups begin to coordinate activities, they begin to look at their policies in terms of sharing information and resources, but there are no formal changes in the any particular agency's policies, procedures, and goals.

Collaboration

When groups come together formally to achieve a common goal, they are collaborating. Collaboration is the process of people, programs, and agencies coming together to define their policies, procedures, and activities in an effort to achieve a common goal. The focus of the collaborating group is to jointly find a solution to a given problem. Collaboration requires shared decision making, resources, and power. ***The key to collaboration is the realization that no one alone has all the power, resources, and expertise to deliver the most effective services possible.*** By giving up traditional roles and coming together, the group members can maximize their skills and knowledge to create a more effective service delivery system.

No single agency or service provider has all the skills and knowledge necessary to meet the multiple needs of a child with disabilities and his or her family.

Activity 2.1

Collaboration involves people from different agencies or programs coming together for the purpose of implementing an effective early intervention program for a child with disabilities and his or her family. List some benefits of collaboration for agencies, service providers, and families.

Benefits to Families	Benefits to Service Providers	Benefits to Agencies

Early Intervention Service Delivery

The degree to which each agency or service provider works together with others determines the nature of the service delivery. The development of cooperative arrangements for the purpose of service delivery is a common strategy that is used for program improvement. Cooperative arrangements are required by many federal laws, and the desired outcome is the development of an interagency cooperative agreement. However, cooperative arrangements rarely result in improved services. This is because cooperating agencies and service providers maintain their own autonomy, as well as their own philosophy and service goals, which may not be appropriate for the target population. Unfortunately, this model tends to drive most initial attempts to organize services for young children with disabilities and their families.

In order to improve this situation, it has been suggested that the focus of early intervention should shift from cooperative arrangements among agencies and providers to collaborations focused on joint service delivery. A collaborative strategy is appropriate in communities where the need and intent is to make a fundamental change the way services are designed and delivered. This requires that the involved agencies and service providers agree on a common philosophy and service goal that can be achieved only through joint agency activities. ***Collaboration is the key to effective early intervention.***

Unfortunately, the development of collaborative early intervention service systems remains an elusive goal for many states. This is not surprising considering that the service delivery system is composed of independent agencies, institutions, and organizations, and each provide a specific service or function. As a result, each participating service provider has his or her own orientation toward the service system. For example, hospitals and health professionals view early intervention very differently from community oriented agencies and professionals. However, Part H of IDEA mandates that many agencies work together to create joint activities focused on the development of collaborative, early intervention services.

Activity 2.2

List the agencies, programs, and services (both public and private) that are available to families with infants and toddlers in your community.

Barriers to Collaboration

Table 2-1 identifies some common barriers to successful collaborations. The following are some of the most common:

Competitiveness Between Agencies and Providers

One barrier to collaboration is competitiveness. Competition between agencies and providers for clients and services often exists. Frequently, conflicts result from a lack of accurate information about the functions of other agencies or providers. Agencies and service providers must be prepared to share information with each other so that barriers to interdependent functioning can be identified and removed. Many existing agency and program policies will need to be evaluated and refined in order to develop collaborative service delivery models.

Table 2-1: Common Barriers to Collaboration

COMPETITIVENESS BETWEEN AGENCIES AND PROVIDERS

- Turf Issues
- Lack of Information About Other's Functions
- Political Issues

LACK OF ORGANIZATIONAL STRUCTURE FOR COORDINATION

- Differing Philosophies
- Independent Goals
- Haphazard Team Process
- Lack of a Facilitator
- Lack of Monitoring and Evaluation Process
- Lack of Planning
- Lack of Power and Authority to Make and Implement Decision

TECHNICAL FACTORS

- Resources: Staff, Time, Budget
- Logistics: Distance, Geography

PERSONNEL

- Parochial Interests
- Resistance to Change
- Staff Attitudes
- Lack of Commitment to Community Needs
- Questionable Administrative Support
- Discipline Specific Jargon and Perspectives

Lack of Organizational Structure for Collaboration

Another collaboration barrier results from a lack of an organizational structure to facilitate coordination between agencies and providers. Traditionally, the goals and philosophies of each agency and service provider are individually established. Therefore, existing agency structures may not

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be conducive to the collaborative planning and implementation of decisions in a cooperative and coordinated manner. The first step in creating a collaborative arrangement is the adoption of a common vision by all involved in the service delivery system. One difficulty in establishing a shared vision may be the existence of differing interpretations of the adequacy of the existing system. This obstacle can only be overcome when all participants are willing to share in a process to ensure open, continued communication, negotiations, and conflict management.

Technical Factors

Technical factors also interfere with service delivery collaboration. Scarce resources of staff, time, and money are factors that inhibit agencies from exerting the time and effort to collaborate with other agencies. In an age of shrinking resources, collaborations are often the only way to guarantee the development of an integrated service system. Logistical issues, such as a distance and geography, are also common excuses for agencies to not work collaboratively.

Personnel

The attitudes of personnel can present the greatest barrier to collaboration. Individuals who resist change will find many reasons why collaboration between agencies and providers cannot occur. Frequently, such resistance indicates of a lack of commitment to the more global needs of children and families, a failure to acknowledge the strengths of other disciplines, or a lack of support from administrative powers. The people involved in the creation, development, and implementation of the collaborative service system are a critical factor in the ultimate success of such a model. Most important is an effective leader. A leader must be able to both establish and "sell" the vision to all participants. He or she also must be able to translate the vision into the reality of service delivery. Also important is the competence and commitment of the other participants, in terms of both policymaking and service delivery. All participants should be provided access to support and training as their roles change with the development and implementation of a collaborative service delivery system.

Activity 2.3

From your own experience, list some examples of the common barriers to the development of collaborative early intervention systems.

Interagency Collaborations

A collaborative service delivery model requires a new structure in which agencies give up some of their autonomy in order to provide optimal services to children and their families.

Under Part H of IDEA, interagency collaboration for the purpose of the design and delivery of early intervention services must occur at both the state and community levels. Ideally, these collaborations will be closely aligned and allow for comprehensive service provision that benefits families and children.

Activity 2.4

How do the agencies that provide early intervention services in your community collaborate?

Though collaboration may not always be possible, it is certainly the most desirable style for professionals from various agencies to use to interact with one another. A more favorable climate for collaboration occurs when agencies, programs or groups share a common philosophy and goal, and the service delivery issue is a priority for each of the service agencies. However, there are several barriers to implementing interagency collaboration. For example, not all participating agencies may agree on the necessity for service improvements. There may be other priorities influencing agencies, such as a budget shortfall, or a history of competition or negative relationships among participants. Nevertheless, federal legislation (Part H of IDEA) for early intervention has clearly created a need to prioritize collaboration, which should facilitate the development of a favorable climate for change to occur.

Activity 2.5

Use the following checklist to assess the status of interagency coordination for early intervention in your community. The checklist has five dimensions of interagency coordination and characteristics that describe each. These characteristics may have a positive or negative influence on interagency collaboration. Please indicate the kind of influence each characteristic has on your interagency group.

Scale: +5 Positive; 4 Somewhat Positive; 3 Neutral; 2 Somewhat Neutral; 1- Negative

CLIMATE							
1.	Past experience in interagency coordination	+5	4	3	2	1-
2.	Decision makers who have worked together over time	+5	4	3	2	1-
3.	Trust level among key individuals	+5	4	3	2	1-
4.	Attitude of key decision maker	+5	4	3	2	1-
5.	Support of key decision makers	+5	4	3	2	1-
6.	Local relationship with state level agency	+5	4	3	2	1-
7.	Interagency cooperation is a priority of program staff	+5	4	3	2	1-
8.	Program goal is priority of the community	+5	4	3	2	1-
9.	Past experience in program area	+5	4	3	2	1-
10.	Delineation of agency roles and responsibilities	+5	4	3	2	1-
RESOURCES							
11.	Availability of financial resources	+5	4	3	2	1-
12.	Availability of personnel	+5	4	3	2	1-
13.	Quality of personnel	+5	4	3	2	1-
14.	Some program components already in place	+5	4	3	2	1-
15.	Funds budgeted to support coordination	+5	4	3	2	1-
16.	Time available for coordination efforts	+5	4	3	2	1-
17.	Availability of options for referral of services	+5	4	3	2	1-
18.	Coordination among resources to avoid gaps and duplication	+5	4	3	2	1-

POLICIES

19.	Existence of federal policies	+5	4	3	2	1-
20.	Existence of state policies	+5	4	3	2	1-
21.	Federal and state policies are clear and understandable	+5	4	3	2	1-
22.	Consistency between state and federal policies	+5	4	3	2	1-
23.	Existence of local policies or guidelines	+5	4	3	2	1-
24.	Consistency between local policies or guidelines and federal and state policies	+5	4	3	2	1-
25.	Existence of local interagency agreements	+5	4	3	2	1-
26.	Definitions of the roles of coordinating agencies	+5	4	3	2	1-
27.	Existence of state level interagency agreements	+5	4	3	2	1-

PEOPLE

28.	Key person(s) provides leadership in acceptance of a shared vision	+5	4	3	2	1-
29.	Key person(s) whose influence crosses agency boundaries	+5	4	3	2	1-
30.	Key person(s) provides leadership in planning and program implementation	+5	4	3	2	1-
31.	Staff have skills in human relations, negotiation, conflict resolution	+5	4	3	2	1-
32.	Staff have diverse skills from various disciplines	+5	4	3	2	1-
33.	Staff recognize the importance of interagency cooperation	+5	4	3	2	1-
34.	Interagency cooperation is a priority of program staff	+5	4	3	2	1-

PROCESSES

35.	Existence of a formal systematic planning process	+5	4	3	2	1-
36.	Existence of a formal communication process (regular meetings, newsletters, policy bulletins, etc.)	+5	4	3	2	1-
37.	Existence of an informal communication network (personal/professional relations)	+5	4	3	2	1-
38.	Existence of a dispute resolution mechanism	+5	4	3	2	1-
39.	Use of participatory planning using all relevant stakeholders	+5	4	3	2	1-

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Harbin, G., Dahaher, J., Bailer, D., & Eller, S. (1991). Status of states' eligibility policy for preschool children with disabilities. Chapel Hill, NC: Carolina Policy Studies Program, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

Collaboration: Predictors of Success

There is no magic formula for developing interagency models, but a number of key ingredients have been identified. In particular, Melaville and Blank (1991) have identified the following five variables that shape an effective interagency collaborative system:

- ***The social and political climate for change.***

  A more favorable climate for collaboration occurs when the targeted service delivery issue is a priority for each of the service agencies.

- ***The processes of communication and problem solving.***

  Interagency collaborations rely on the adoption of a process to establish goals and objectives, clarify roles, make decisions, and resolve conflicts.

- ***The human dimension.***

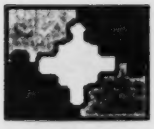
  The people involved in the creation, development, and implementation of the interagency service system are a critical factor in the ultimate success of the collaborative model.

- ***The policies that support or inhibit interagency collaboration.***

  Each participating agency and program entering into an interagency collaboration has a set of rules and regulations which governs its mandate, target population, budgetary operations, and service structure (including staffing patterns). Agencies and programs must be prepared to identify and share these policies with each other so that barriers to interdependent functioning can be identified and removed.

- ***The availability of resources.***

  Interagency collaborative efforts require new fiscal arrangements to ensure the development and delivery of services. Resources of all kinds (fiscal, staff, time, in-kind services) will have to be pooled to establish the most efficient delivery of services. In an age of shrinking resources, interagency collaborations are often the only way to guarantee the development of an integrated service system. Early intervention is one area in which resources must be jointly pooled and funding levels must be increased. Only then will states be able to implement services in conjunction with the spirit of Part H of P.L. 99-457.



Activity 2.6

Using the five predictors, describe the conditions for interagency collaboration in your community's early intervention program/system.

The social and political climate for change.

The processes of communication and problem-solving.

The human dimension.

The policies that support or inhibit interagency collaboration.

The availability of resources.

In both cooperative and coordinative partnerships, the needs of the interagency effort are secondary to the needs of the single agencies. In a collaborative effort, the interagency effort is seen as a separate entity. As such, it has needs that parallel those of the individual agencies. Staff members must have loyalty to both the interagency program's goal and to their single agencies. Decision making authority rests with the interagency group, whereas in cooperative and coordinative efforts, decision making typically lies with the individual agencies. The interagency group needs to develop collaborative procedures that foster conflict resolution, enhance trust, determine the benefits to be derived from all participants, share information, and create an effective decision making mechanism.

The development of trust is essential in order for the interagency goal to be met. Consensus building only works when the participants trust that everyone is committed to the same objectives with no "hidden agendas," and when each single agency believes that it is getting enough benefits from the collaboration to justify the investment of resources that it is making. It is important for each agency to have the opportunity to discuss what it hopes to get out of the collaboration, and to have input into the design of processes and procedures for the management of the interagency unit.

Barriers to a successful change process are related to external forces, motivation, leadership, and operational factors. Attention must be paid to these barriers to prevent the process from stalling out.

--Carl L. Hirshman and Steven L. Phillips

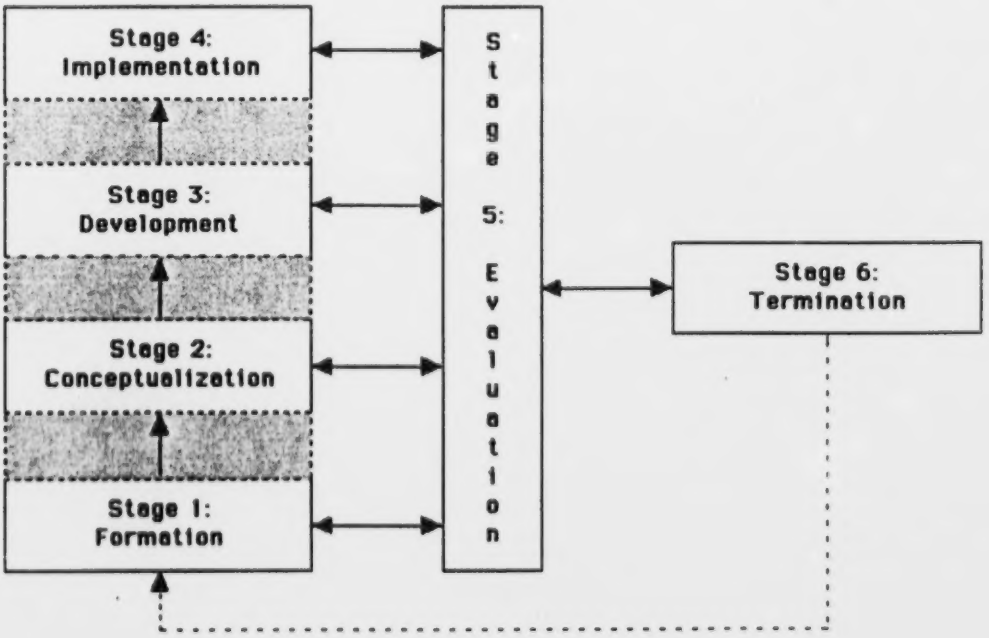
Activity 2.7

Draw an organizational chart of key early intervention players (agencies, task forces, committees, etc.) in your community. Next, identify strengths, opportunities, barriers, and strategies for effecting change within the organization.

The Development of Interagency Collaborations

There have been many theories put forth about organizational development, with a finite number of stages identified and described. Progression through these stages often appears linear, but in reality collaborative groups often find themselves overlapping some of the stages as they progress. Kagan (1991) outlines six stages in the life of an interagency collaborative process.

Kagan's Stages of Interagency Collaborative Process



Formation

In this stage, someone initiates the idea of collaboration; it is the visioning stage. The vision arises in response to a potential or actual problem, and the initiating individual identifies others who then become stakeholders in the process. These stakeholders together explore the viability of the vision; they become acquainted with each other and their programs, partly to assess turf issues; and, they begin to identify a global mission.

Conceptualization

This stage begins when participants adopt a formal policy statement and objectives. They discuss each person's expectations and reasons for participating in the collaboration. They agree on a common purpose and direction. This is the stage in which tasks, roles, and responsibilities are delineated, and a decision-making model and administrative structure for future interagency activities are developed.

Development

Here a formal structure is developed that will sustain the interagency entity. The group identifies programs for revision or expansion, establishes a communication system, assigns work group tasks, and selects locales in which the work will take place. Issues and conflicts within the group are addressed and resolved, plans are formulated, and seek acceptance from the key decision-makers in their own agencies.

Implementation

This is the action-intervention stage, when the proposed revisions are put into place. Decisions are carried out at the administrative and service delivery levels. Policy changes are made to comply with decisions made in previous stages, agencies interact accordingly, and services are improved.

Evaluation

Evaluation in any collaborative venture is an ongoing process, and should be conducted continuously. The unit must always look at how accomplishments measure against expectations, and whether the vision is becoming a reality. Evaluative efforts should look at four dimensions: 1) the effectiveness of the process (i.e., the relationship between goals and actual results); 2) equity; 3) the adequacy of the effort, (i.e., were

enough resources dedicated to the effort to achieve the desired results); and, 4) cost efficiency (i.e., was the maximum return achieved from the monetary investment).

Evaluation takes place at several levels simultaneously. The first is the level of the *client*: Is service delivery improving as anticipated? The second is the level of the *provider*: Is the job easier as a result of the collaborative effort? The third is the level of *administrators and funders*: Are costs reduced and waste eliminated?

Termination

Termination occurs when the collaboration is no longer needed -- either because the initial problem has been solved, or because the benefits of collaboration have failed to outweigh the costs. The end of one collaborative venture may precipitate the beginning of another, as systems and structures are scrutinized and new procedures are developed to meet the needs of a changing environment.

Activity 2.8

Describe an interagency group you may be involved with and try to determine which of the six steps you are focused on currently.

Activity 2.9

At which level are Polly's early interventionists working: coordination, cooperation or collaboration?

Describe the current barriers their team is experiencing.

Describe the benefits that Polly and her family would experience from a collaborative approach to service delivery.

Notes

Every child is a member of a family (however it defines itself) and needs a home and a secure relationship with an adult or adults. These adults create a family unit and have ultimate responsibility for caregiving, supporting the child's development, and for enhancing the quality of the child's life. The caregiving family must be seen as the constant in the child's life, and therefore, the primary unit for service delivery. Early interventionists must respect the individual families they serve, and the decisions of these families in directing their children's early intervention programs.

Traditionally, families have been viewed as being comprised of a husband, wife and children, living comfortably together in their own home. However, this definition does not describe most families today. Anthropologists, sociologists, and other professionals who study people and their social relationships have struggled to answer the question, "What is a family?" Nearly every one of us has grown up in a family and has a sense of what a family is. Yet, it is extremely difficult to create a definition that includes all the variations of a "family."

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Activity 3.1

Take a few minutes to write your definition of a "family."

Now examine your definition and consider the following questions:

- Does your definition include single parents raising children?
- Does your definition include grandparents and foster parents raising children?
- Does your definition include extended family members?

The traditional concept of an "ideal family" can be harmful because the definition of a "traditional" family, which has a married mother and father living together with their children causes us to label families who don't fit this pattern as "abnormal." For example, single parents, unmarried adults raising children, or childless couples are often seen as social problems. Variations in the makeup of families

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are common. When non-traditional families are viewed as problems, we fail to recognize and respect a family's strengths. Secondly, only a small percentage of families today actually resemble the traditional family. In fact, according to the 1990 Census Data, only 37.2% of families living in the United States and 35.3% of families living in Connecticut fit the definition of the "traditional family".

An updated, more relevant definition of "family" was developed by a legislative task force on young children and their families in New Mexico. This definition describes the concept of family:

"We all come from families. Families are big, small, extended, nuclear, multi-generational, with one parent, two parents, and grandparents. We live under one roof or many. A family can be as temporary as a few weeks, as permanent as forever. We become part of a family by birth, adoption, marriage, or from a desire for mutual support. As family members we nurture, protect and influence one another. Families are dynamic and are a culture unto themselves, with different values and unique ways of realizing dreams. Together, our families become the source of our rich cultural heritage and spiritual diversity. Each family has strengths and qualities that flow from individual members and from the family as a unit. Our families create neighborhoods, communities, states, and nations."

No two families are exactly alike. Families differ in their size, their composition, and how they function. Most importantly, all families have strengths.

Parenting a Child with Disabilities

Parents of young children with disabilities rarely take on this parenting role with any preparation for the special challenges they will face. Rather, the early days, weeks and months of parental responsibility may be spent in a blur of visits to the hospital, physician's office and special clinics with little or no opportunity to adapt to the significant change that has taken place in their lives. While most parents report an increase in the level of stress they perceive after the birth of a child, the parents of an infant with disabilities must deal with unanticipated pressures and responsibilities that can make the parenting role appear to be overwhelming.

Parents traditionally have been an integral part of early intervention

services. By far, their most significant role has been that of service provider or teacher of their child. The implementation of this parent role represents a somewhat restricted view of parent involvement. All too often, early intervention parent training programs have imposed intrusive demands and expectations on parents that have altered their interactional style with both the child with disabilities and the rest of the family.

The application of family systems theory has prompted the recommendation that early intervention programs move away from a narrow focus of the child and encompass the broader and self-identified needs of the enrolled parents. The primary goal of early intervention should be to facilitate the parents' awareness of, and adaptation to, their primary role of parenting a child with disabilities. One key to accomplishing this goal is to recognize the ongoing stress of parents and assist them to identify and recruit support networks. By changing the focus from child change to parent-family adaptation, both programs and parents will see beneficial results.

Family support strategies should be integral to any service delivery system for families with infants and toddlers who have disabilities. The support strategies should be both formal (e.g., assistance with insurance and financial needs; identification of respite services; training on medical equipment) and informal (e.g., identifying existing community resources; facilitating family involvement within the school). The overriding premise of such support is that it must be individually matched to the needs of the family, and the use of such strategies should be directed by the family.

The story, "A Trip to Holland," was written by a parent describing how she felt upon the birth of her child who was identified as having Down syndrome.

We must respect a family's priorities and support their choices, no matter how different from ours they may be.

A Trip to Holland

When you're going to have a baby, it's like you're planning a vacation to Italy. You're all excited seeing the Coliseum, the Michaelangelo, the gondolas of Venice. You get a whole bunch of guide books, you learn a few phrases in Italian, so you can order in restaurants and get around the town. When it comes time, you excitedly pack your bags, head for the airport, and take off for Italy. Only when you land, your stewardess announces, 'Welcome to Holland' You look at one another in disbelief and shock, saying 'Holland? I signed up for Italy.' But they explain that there's been a change of plans and the plane has landed in Holland, and there you must stay. 'But I don't know anything about Holland. I don't want to stay here,' you say. 'I never wanted to come to Holland. I don't know what you do in Holland, and I don't want to learn.' But you do stay, and you go out and you buy some new guide books. You learn some new phrases in a whole new language, and you meet people that you never knew existed. But the important thing is that you are not in a filthy, plague infested slum full of pestilence and famine. You are simply in another place, a different place than you'd planned. It's slower paced than Italy, less flashy than Italy, but after you've been there a little while and you have a chance to catch your breath, you begin to discover that Holland has windmills, Holland has tulips, and Holland even has Rembrandts. But everyone you know is busy coming and going to and from Italy, and they're all bragging about what a great a time they had there. And for the rest of your life you will say 'Yes, that's where I was going; that's where I was supposed to go; that's what I planned.' And the pain of that will never, ever go away. And you have to accept that pain, because the loss of that dream, the loss of the plan, is a very, very significant loss. But if you spend your life mourning the fact that you didn't get to Italy, you will never be free to enjoy the very special, the very lovely things about Holland.

--Emily Kingsley

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Activity 3.2

List family support services that are available in your community.

Family Centered Care

Family-centered care refers to a set of beliefs, attitudes, and principles that have been applied to the care of children with special healthcare needs and their caregiving families. The philosophy of family-centered care is based on the fact that the family is the enduring and central force in the life of a child, and has a large impact on his/her development and well-being. Table 3-1 contains a list of the principles of family centered care, and they are further described.

Table 3-1: Principles of Family-Centered Care

1. Acknowledge the family as the constant in a child's life.
2. Facilitate collaboration at all levels of care.
3. Share unbiased and complete information with family members about their child's care on an ongoing basis, and in an appropriate and supportive manner.
4. Implement appropriate, comprehensive services that provide emotional and financial support to meet the needs of families.
5. Recognize the family's strengths, individuality, and methods of coping.
6. Understand and incorporate the developmental needs of infants, toddlers, and families into everyday routines and activities.
7. Encourage and facilitate parent-to-parent support.
8. Assure that services are flexible, accessible, and responsive to the family's needs.
9. Honor the racial, ethnic, cultural, and socioeconomic diversity of families.

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- ***Acknowledge the family as the constant in a child's life.***

  Early intervention is part of a child's life for a relatively short period of time. It is essential to recognize and respect the central and lasting role the family plays in the child's life.

- ***Facilitate collaboration at all levels of care.***

  Successful intervention depends on the ability of families and early intervention service providers to work together as partners. It is important to respect the skills, abilities, knowledge, and individual dreams of families.

- ***Share unbiased and complete information with family members about their child's care on an ongoing basis, and in an appropriate and supportive manner.***

  Each family has the right to know all the information available about their child's needs and the service options available to meet those needs. This information should be shared in an open, honest, understandable, and sensitive manner.

- ***Implement appropriate, comprehensive services that provide emotional and financial support to meet the needs of families.***

  Each family is unique, with its own concerns, priorities, and hopes for the future. A family's needs may include respite, childcare, parent-to-parent support, transportation, and assistive technology. The family must have access to the supports and services necessary to meet those needs.

- ***Recognize the family's strengths, individuality, and methods of coping.***

  All families have individualized coping behaviors that they use on a daily basis. Services must recognize the appearance and value of these behaviors to each member of the family.

- ***Understand and incorporate the developmental needs of infants, toddlers, and families into everyday routines and activities.***

  Families of children with medical or developmental needs continue to have the need to "be a family."

Every family needs time to enjoy friends, recreation, community activities, and each other. Early intervention should encourage and support the child's participation within the family's daily activities.

- ***Encourage and facilitate parent-to-parent support.***

  Parent-to-parent support provides families with an opportunity to share and benefit from each other's experiences and knowledge. Early interventionists can best support families by being aware of local advocacy and support organizations.

- ***Assure that services are flexible, accessible, and responsive to the family's needs.***

  Families often report that inflexible services are a greater source of stress than the care of their children. Programs and policies must be responsive to the dynamic needs and goals of families.

- ***Honor the racial, ethnic, cultural, and socioeconomic diversity of families.***

  Each family has its own beliefs, values, and preferences. Early interventionists can support families by being open to and accepting of diversity.

Family-centered care suggests that all services revolve around the family, as it is the family that will be the constant in the child's life. Early interventionists must become sensitive to the changing needs of the family as it copes with the ongoing needs of the child. Empathetic staff and flexible, coordinated family-centered services are crucial to the design of a collaborative early intervention service system.

Family-centered care requires that professionals should look closely at what they do now and envision what they can create. Look closely at their current practices and ask questions such as: Why are things done this way? Is this the only way possible? Is this the best way to do it? Is this the way it has always been done?

Activity 3.3

Using the following definitions, assess whether the examples listed below are family-centered, child-centered or system-centered.

Driving Forces:

S System-centered: the strengths and needs of the system drive the delivery of services.

C Child-centered: the strengths and needs of the child drive the delivery of services.

F Family-centered: the strengths and needs of the family drive the delivery of services.

__ A family must bring their child to the office for case management services.

__ A complete assessment of a child and family is done.

__ Occupational therapy sessions are arranged according to a family's schedule.

__ Child care is provided for siblings while the child with disabilities receives treatment.

__ The office hours of the dentist are Monday through Friday, 9:00 a.m. - 4:00 p.m.

__ A physical therapist sends the order for a seating device home with the child.

__ Transportation to the clinic is available from 9:00 a.m. - 5:00 p.m.

__ Parent support groups may use the facility's conference room in the evenings.

__ A local school board's planning committee consists of professionals, parents, and representatives from the community.

__ A child's medical records are available in three to five days after a release of information is received.

__ A speech therapist comes to the home twice a week for a one hour session with a child.

__ A care plan developed by a multidisciplinary team is given to the parent.

__ School is closed for a day so that parent/teacher conferences can be held.

__ Parents choose to send their child with diabetes to a church camp instead of a special camp for children with diabetes.

__ A hospital social worker arranges for all of the medical equipment ordered by a physician for a child.

Cultural Diversity

Just as the population of children who are considered to have special needs is not a homogeneous group, neither are the children's families. The early intervention professional serving infants and toddlers with disabilities will work with many families who vary by background and economic conditions, as well as by family structure. Each family will bring unique resources to the task of parenting their child with special needs, and each family will identify unique needs which must be addressed through early intervention.

In addition, early intervention programs are becoming much more sensitive to the cultural background of the enrolled families. This important variable contributes to the composition and operation of a family system. The families of infants and toddlers in the early intervention system represent all facets of American society and cultural backgrounds. The basic cultural components that must be considered as professionals work with families include language, communication style, religious beliefs, values, customs, food preferences and taboos; any of these factors may affect the family's perception of disabilities. Early interventionists must have the ability to understand the similarities and differences between their own cultural beliefs and values and those of the families they serve. The influence of cultural norms can be more significant than the influence of a specific intervention. Early interventionists must develop a sensitivity to the unique role these variables play in each family system.

Diversity should be valued. Diversity is not right or wrong. Diversity is a dimension of being that emphasizes the uniqueness of each and every one of us.

The first step in learning to be sensitive involves self-awareness. The awareness of individual assumptions and values can help to sensitize early interventionists to the belief system of the families receiving services. It is important to recognize that one viewpoint represents just one of the many ways to look at the world.

In addition to recognizing how values affect decisions and judgments, early interventionists must learn about differences in the cultures of the families served in early intervention. Knowledge and understanding of various cultures will enable the early intervention system to support families through the IFSP process. Cultural sensitivity means being aware and respectful of the unique cultural needs, values, and norms of a child and family. To demonstrate cultural sensitivity, early intervention service providers should:

- Recognize the diversity of other cultures.
- Develop individualized family service plans that are culturally acceptable.
- Establish clear communication (verbal and nonverbal) with all families (through bilingual and bicultural staff).
- Provide all information in the family's preferred language.
- Encourage respect for different values, beliefs, and practices.
- Cross language barriers and gain access to needed community services facilitating family empowerment.

Families should be at the center of the service delivery system.

Activity 3.4

Early intervention must be consistent with the family's beliefs and values. In order to provide effective services, we must learn more about the family's values and preferences. These preferences can include the family's:

- feelings toward seeking assistance from people outside the family.
- beliefs regarding food and mealtime rules.
- views on acceptable behavior for children.

List some of your family's beliefs, values, and priorities, and identify their origin.

The Family-Centered IFSP

The Individualized Family Service Plan (IFSP), mandated by Part H, is the keystone to the services provided to an infant or toddler with disabilities and his or her family. The plan must be written carefully to include the needs of the child, and the parents or other caregivers as related to the child's needs. With the focus on least restrictive, natural environments and family-centered care, there must be respect for the role of the family members. They are the people who know the child best, and who can delineate most accurately the child's strengths and needs.

Elements of an IFSP:

1. Information about the child's status, including present levels of physical development (vision, hearing, and health status), cognitive development, language and speech development, psychosocial development, and self-help skills, based on professionally acceptable objective criteria.

2. A statement, made with the concurrence of the family, of the family's concerns, priorities, and resources related to enhancing the developmental outcomes of the child.

3. A statement of the major outcomes expected to be achieved for the child and family and the criteria, procedures, and timelines used to determine: a) the degree to which progress toward achieving the outcomes is being made; and, b) whether modifications or revisions of the outcomes or services are necessary.

4. A statement of the early intervention services necessary to meet the unique needs of the child and family to achieve the stated outcomes including: a) the frequency, intensity, location, and method of delivering services; b) the payment arrangements, if any; and, c) the dates and duration of the services. (Frequency and intensity define the number of days or sessions that a service will be provided, the length of time the service is provided during each session, and whether the service is provided on an individual or group basis. Location means the place where the service is provided. Method means how the service is provided. Date means the specific day the service will start and the anticipated number of weeks or months of those services will be provided.)

5. A listing of other services that the child needs that are not required under the federal Early Intervention

Program for Infants and Toddlers with Disabilities and the steps that will be taken to secure services through private or public resources.

6. The name of the service coordinator who will be responsible for the implementation of the IFSP and coordination with other agencies and persons.

7. A listing of the steps to be taken to support the transition of the child, upon reaching age three, to public school preschools or preschool services under Part B of the IDEA or other services that may be available, as is appropriate for the child's needs.

Activity 3.5

In order to develop a family-centered IFSP, both early intervention service providers and families must collaborate in the process.

Describe what information and skills early intervention service providers and parents contribute to the development of the IFSP.

Professionals	Parents

Family Concerns, Priorities and Resources

In order to develop an effective IFSP for infants and toddlers with disabilities, early interventionists must become aware of each family's concerns, priorities, and resources. Furthermore, staff must be able to communicate with the family in order to establish collaborative goals for the child, and to design appropriate interventions that can be delivered in the context of the family. A family-centered approach to providing services to children and families is dependent on a relationship between early interventionists and families that is based on mutual trust and respect.

Knowledge of the family's concerns, priorities, and resources can be gained through periodic interactions with the family. Phone calls, home visits, and casual conversations are all opportunities to learn more about the family. These contacts can be used to identify:

- The names and roles of important people in the family's life.
- Questions the family would like answered.
- The child's history.
- The child's strengths and other relevant information such as favorite toys and games.
- Things the family finds to be difficult (e.g., locating sources of financial support, speaking with physicians about the child's care, filling out insurance forms).
- The family's typical routine and activities.

Early intervention service providers must be open and sensitive to what a family has to say. Families are more comfortable and willing to share their concerns when they sense trust and respect.

Certain guidelines can assist service providers and families when collaborating to identify a family's concerns, priorities, and resources. These include:

❖ ***The inclusion of family information in the IFSP is voluntary, not mandatory.***

Regulations do not require that family members participate in activities to identify their family's strengths and needs. Family information is included in the IFSP only with the family's consent.

- ***A need exists only if the family feels it exists.***

  To provide family-centered services, early interventionists must recognize the difference between helping families to identify their needs and leading families to agree with the needs they may see.

- ***Only family members can determine what aspects of their lives are relevant to the child's development.***

  The family has the right to decide what personal family information is relevant to its child's care. Early intervention service providers must respect the decisions a family makes. Only family information directly related to the family's expressed needs should be discussed. The family should never feel pressured to share sensitive, personal information.

- ***Families must have ongoing opportunities to identify their evolving needs and concerns.***

  Family responsibilities and concerns can change rapidly or slowly. Family members must be provided with ongoing opportunities to share their thoughts and concerns as they evolve.

The Role of the Family in the IFSP Process

The family plays a leading role in the development of an IFSP, which provides the infant or toddler the best possible early intervention program including:

Referral for Services

Anyone involved with the child (family members, professionals providing services to the family, childcare workers, etc.) can make a referral to the early intervention system, as long as the parents give permission. The first responsibility of the early intervention system is to determine the family members' concerns and priorities in regard to their child's development.

Evaluation/Assessment Planning

Evaluation determines if the infant or toddler is eligible for early intervention, while assessment of the child's strengths and needs is an ongoing process. As the child grows and develops, assessments will change; and, as the team, including the family, becomes more comfortable with each other, additional insights may arise. In the traditional assessment model, the family's needs and wants were not taken into account until after the service provider completed the

assessment. In the IFSP, as outlined by Part H, the family's needs, wants, and goals are essential to the process, and must be identified before any assessment activities are planned.

Language associated with the assessment should reflect family values and preferences as much as possible. Some families dislike or misunderstand the term "evaluation," thinking of it as a test of some kind that may be passed or failed. Service providers on the team should pay attention to the language the family uses, and should feel free to ask the family what terms they prefer, and then use those terms throughout the tenure of their relationship.

The team needs to gather and exchange information in the following areas when planning an assessment:

- Child characteristics.
- Family preferences for involvement.
- Family priorities for both the child and family.
- Child records and other data from previous assessments or diagnoses.

Asking parents such questions as where they would like the assessment to take place, what activities and toys their child favors, what time of day their child naps, who should be present at the assessment, and what role the parents prefer during the assessment (e.g., helping with activities, sitting quietly beside the child, or carrying out some of the activities) will ensure that parents are involved to the extent that they desire, and that the child will be treated according to the family's wishes.

Assessment of a Child's Strengths and Needs

All assessment activities must be carried out with the signed informed consent of the parents. Formal observations or assessments should be used only when absolutely necessary, and then only with the consent of the parent or legal guardian. Unless the parents specifically choose not to be present at all meetings and assessment activities, they should to be included in all team activities.

It is important to assess the child's strengths, as well as his or her needs. Early intervention service providers are often focused on what the child *cannot* do, and they may need help in recognizing what he or she *can* do, and what the family has

learned from living with the child. Insight about a child's strengths can be gained by asking parents for information such as: 1) a description of the child, or a typical day with the child; 2) what the child likes to do; and, 3) recent changes or progress the child has experienced.

The assessment must focus on the child's current level of functioning, including physical, emotional, social, learning style, language development, and personal independence abilities. There are many standardized tests, checklists, and observational measures available to gather this information. The assessment needs to be tailored to the individual child, and to the wishes of the family.

Assessment results must always be shared openly and honestly with all members of the team. Parents and service providers discuss the findings so that everyone has a complete understanding of the results and interpretations.

Identification of the Family's Concerns, Priorities, and Resources

The family's self-identified concerns, priorities, and resources are shared with the whole team through informal discussions, home visits, phone calls, and any other methods used by the family.

Development of Outcomes

Outcomes are the changes the family want to see happen for the child and the entire family system. Outcomes can be related to any area of a child's development or family life. For example, a family's outcomes may include the development of specific skills related to eating, playing or dressing, or the ability of the parents to go out occasionally while their child is in the care of someone they trust. Outcomes, like the other sections of the IFSP, are written without jargon, and focus on useful skills.

Implementation and Service Delivery

The implementation of the IFSP delivers the actual services and supports to meet the needs of the child and family. As with the assessment plan, service delivery must be family-centered, responsive to emerging needs, supportive of family strengths, and above all, flexible.

The family will decide how involved they want to be in the actual provision of services. Some families may want to be very involved, while others may choose to be minimally involved. The degree of involvement may change as the family's needs change, and the team must be sure that the family is supported in its decision, whatever that decision may be.

Activity 3.6

Describe how families are currently involved within your agency or program in each of these six components of the IFSP process.

Referral for Services

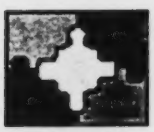
Assessment Planning

Assessment of a Child's Strengths and Needs

Identification of the Family's Priorities, Resources, and Concerns

Development of Outcomes

Implementation and Delivery of Services



Now think about Polly and her parents. What role is Polly' family playing in the IFSP process?

Is Polly's service delivery child-, family- or system-centered?

What things can be done to make Polly's service delivery less stressful on her family?

Notes

While infants and toddlers with disabilities may require the combined expertise of numerous professionals providing specialized services, the coordination of both people and services is frequently overwhelming. For example, personnel having medical expertise, therapeutic expertise, educational/developmental expertise, and social service expertise traditionally have been involved in the provision of services to infants and toddlers with disabilities and their families. Each of these service providers may represent a different professional discipline and a different philosophical model of service delivery. In fact, each discipline has it own training sequence (some require undergraduate, while others require graduate degrees), licensing or certification requirements (most of which do not require age specialization for young children), and treatment modality (e.g., occupational therapists may focus on sensori-integration techniques). In addition, many disciplines have their own professional organization that encompasses the treatment needs of persons across the entire life span, instead of organizations focused on a single age group. Nonetheless, as

services for young children with disabilities continue to grow, so too does the need for professionals. Table 4-1 contains a list of the professional disciplines most typically involved in services for young children with disabilities and their families.

In order to improve the efficiency of the individuals providing early intervention, it has been suggested that services be delivered through a team approach. A group of individuals does not become a team spontaneously. A group becomes a team when its members work together to accomplish shared goals. Team members pool their knowledge to solve common problems and implement mutually agreed upon solutions.

Activity 4.1

Think about your own experiences with groups of people on teams, committees, or boards. What helped the group function well?

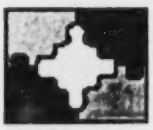


Table 4-1: Professional Disciplines in Early Intervention

- Audiologist
- Early childhood special educator
- Neurologist
- Nutritionist
- Nurse
- Occupational therapist
- Ophthalmologist
- Optometrist
- Physician
- Psychologist
- Physical therapist
- Social worker
- Speech-language pathologist
- Vision specialist

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Effective Teams

A truly effective team exists when members share responsibility for accomplishing common goals. An effective team will:

- ***Have goals which are clearly understood and communicated to all team members.***

  A collaborative philosophy or mission provides the team's overall reason for existence and a focus for its actions. A written statement of the collaborative philosophy will clearly delineate the team's direction. A team will function effectively to the extent that its philosophy is clear and accepted by all of its members.

- ***Recognize the contributions of all team members.***

  Effective teams are supportive, creating an environment where every team member feels comfortable and free to express his or her concerns, thoughts, and reactions. There is no single person who is more important than any other on an effective IFSP team.

- ***Communicate effectively among members.***

  Effective communication occurs when the listener clearly understands the speaker's intended message. Team members communicate effectively when they listen to what others are saying and respond using language that is understandable and jargon free. While jargon makes it easy for service providers within a particular discipline to communicate with each other, it makes it difficult for a team composed of multiple disciplines and family members to communicate effectively. Miscommunications can occur when individual team members assign different meanings to the same terms.

The highest level of achievement is attained when the whole team is committed to the task, and full use is made of each member's talents.

Activity 4.2

Use the chart below to determine if a group you are in is functioning as a team.

GROUPS	TEAMS
❑ Members think they are grouped together for administrative purposes only. Individuals work independently; sometimes at cross purposes with others.	❑ Members recognize their interdependence and understand both personal and team goals are best accomplished with mutual support. Time is not wasted struggling over "turf" or attempting personal gain at the expense of others.
❑ Members tend to focus on themselves because they are not sufficiently involved in planning the unit's objectives. They approach their job simply as a hired hand.	❑ Members feel a sense of ownership for their jobs and unit because they are committed to goals they helped establish.
❑ Members are told what to do rather than being asked what the best approach would be. Suggestions are not encouraged.	❑ Members contribute to the organization's success by applying their unique talent and knowledge to team objectives.
❑ Members distrust the motives of colleagues because they do not understand the role of other members. Expressions of opinion or disagreement are considered divisive and non-supportive.	❑ Members work in a climate of trust and are encouraged to openly express ideas, opinions, disagreements and feelings. Questions are welcomed.
❑ Members are so cautious about what they say that real understanding is not possible. Game playing may occur and communications traps be set to catch the unwary.	❑ Members practice open and honest communication. They make an effort to understand each other's point of view.
❑ Members may receive good training but are limited in applying it to the job by the supervisor or other group members.	❑ Members are encouraged to develop skills and apply what they learn on the job. They receive the support of the team.
❑ Members find themselves in conflict situations which they do not know how to resolve. Their supervisor may put off intervention until serious damage is done.	❑ Members recognize conflict is a normal aspect of human interaction but they view such situations as an opportunity for new ideas and creativity. They work to resolve conflict quickly and constructively.
❑ Members may or may not participate in decisions affecting the team. Conformity often appears more important than positive results.	❑ Members participate in decisions affecting the team but understand their leader must make a final ruling when the team cannot decide, or an emergency exists. Positive results, not conformity are the goal.

From: Maddux, R.E. (1988). Team building: An exercise in leadership. Crisp Publications

The types of teams that typically function within service delivery models for young children with disabilities have been identified as multidisciplinary, interdisciplinary, and transdisciplinary. While the transdisciplinary team model has been identified as the ideal for early intervention, other team models have also been identified and used for service delivery. A number of components that differentiate between types of teams have been identified, including the role of the family on the team, the mode of communication among team members, the role-clarification process, and the mode of intervention. Table 4-2 provides an overview of the three team models.

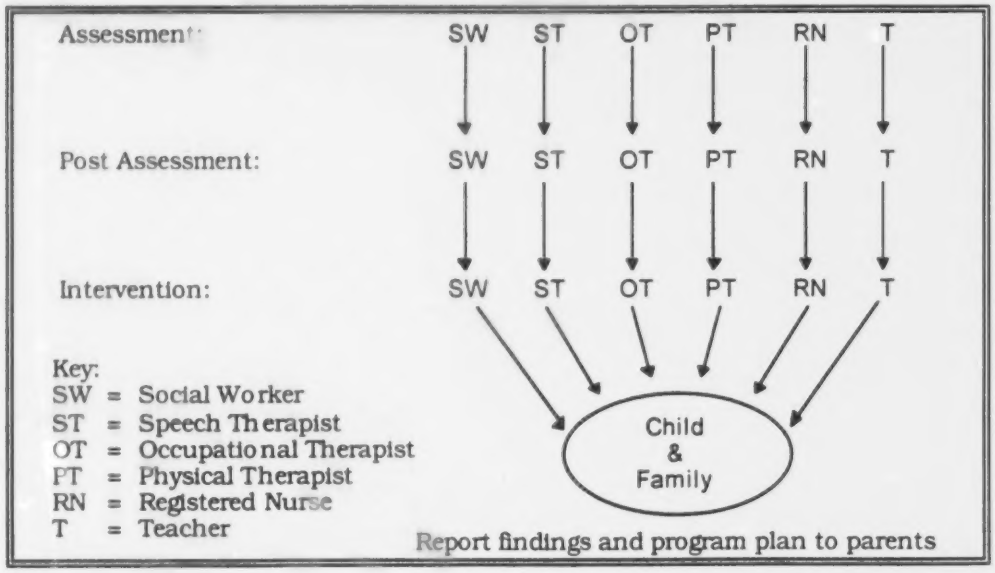
Table 4-2: Team Models

	MULTIDISCIPLINARY	INTERDISCIPLINARY	TRANSDISCIPLINARY
Guiding Philosophy	Team members recognize the importance of contributions from other disciplines.	Team members are willing and able to develop, share, and be responsible for providing services that are a part of the total service plan.	Team members make a commitment to teach, learn, and work together across discipline boundaries to implement a unified service plan.
Family Participation	Family meets with individual team members.	Family meets with team or team representative(s).	Family is full, active, and participating member of the team.
Assessment	Separate assessments by team members.	Separate assessments by team members; may use common tool.	Team members and family plan and conduct a comprehensive assessment together.
Goal Setting	Team members develop separate plans for their discipline.	Team members share their separate plans with one another.	Team members and family develop a service plan based upon family concerns, priorities, and resources.
Treatment	Team members implement the part of the service plan related to their discipline.	Team members implement their section of the plan and incorporate other sections where possible.	A primary service provider is selected to implement the plan with the family.
Lines of Communication	Informal lines.	Periodic case-specific team meetings.	Regular team meeting where continuous transfer of information, knowledge, and skills are shared among team members.

Multidisciplinary Teams

On a multidisciplinary team, the professionals represent their own discipline and provide isolated assessment and intervention services. This includes individual report writing, individual goal setting, and discipline-specific direct intervention with the child and/or family. The parent is invited to share information with the professionals, and the professionals in turn share the information from assessment, intervention, and follow-up with the family through an "informing" conference. There is minimal integration across the disciplines, and the family members are passive recipients of information about their child. This model makes it very difficult to develop coordinated integration across the disciplines, and the family members are passive recipients of information about comprehensive programs for families and their children. Figure 4-1 contains an overview of this type of team.

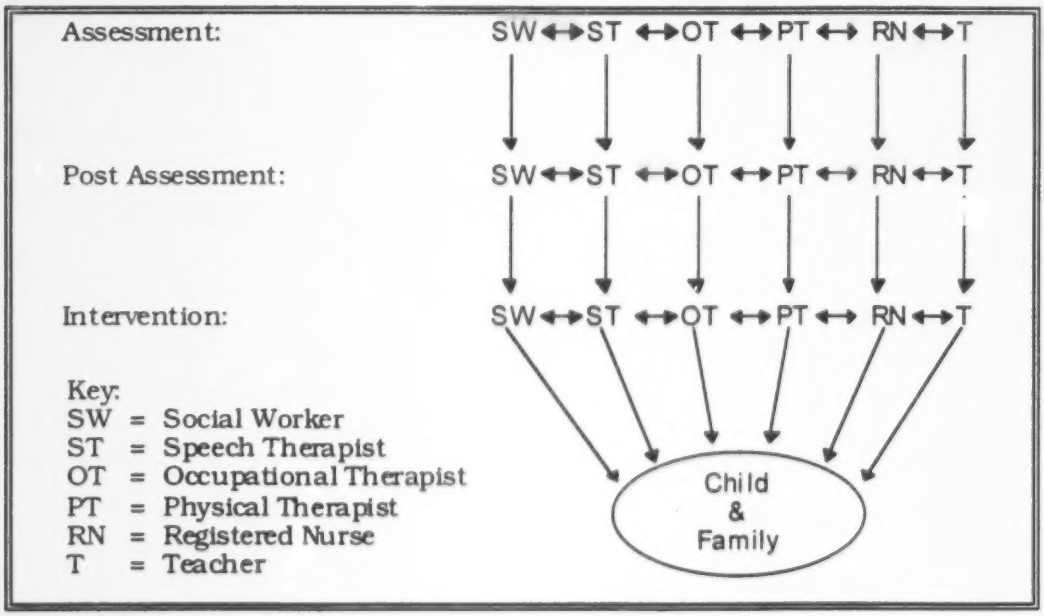
Figure 4-1: Flow of Information on a Multidisciplinary Team



Interdisciplinary Teams

On an interdisciplinary team, each of the professionals carries out specific disciplinary assessments and interventions. The degree of communication between the professionals and the family represents a formal commitment to the sharing of information throughout the process of assessment, planning, and intervention. However, the assessments and interventions are usually implemented by individuals representing separate disciplines. In many cases, the parents are active members of the team, but their input is generally considered secondary in importance to the material collected by the professionals. Figure 4-2 contains an overview of this type of team.

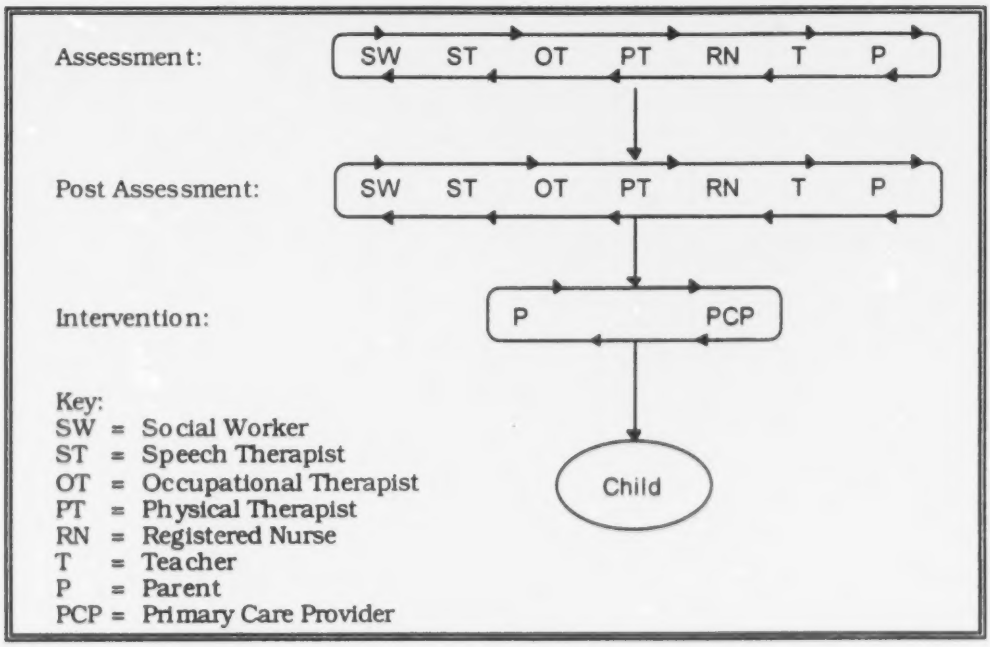
Figure 4-2: Flow of Information on an Interdisciplinary Team


Assessment:
SW ↔ ST ↔ OT ↔ PT ↔ RN ↔ T
Post Assessment:
SW ↔ ST ↔ OT ↔ PT ↔ RN ↔ T
Intervention:
SW ↔ ST ↔ OT ↔ PT ↔ RN ↔ T
Key:
SW = Social Worker
ST = Speech Therapist
OT = Occupational Therapist
PT = Physical Therapist
RN = Registered Nurse
T = Teacher
Child & Family

Transdisciplinary Teams

The transdisciplinary approach originally was conceived as a framework for professionals to share important information and skills with primary caregivers. This approach integrates a child's developmental needs across the major developmental domains. The transdisciplinary approach involves a greater degree of collaboration than other service models and, for this reason, may be difficult to implement. It has, however, been identified as ideal for the design and delivery of services for infants and toddlers with disabilities receiving early childhood intervention. Figure 4-3 contains an overview of this type of team.

Figure 4-3: Flow of Information on a Transdisciplinary Team



A transdisciplinary approach requires the team members to share roles and systematically cross discipline boundaries. The primary purpose of the approach is to pool and integrate the expertise of team members so that more efficient and comprehensive assessment and intervention services may be provided. The communication style in this type of team involves continuous give and take between all members (especially the parents) on a regular, planned basis. The team members teach, learn, and work together to accomplish a common set of intervention goals for a child. Role differentiation between disciplines is defined by the needs of the situation, as opposed to discipline-specific characteristics. Assessment, intervention, and evaluation are carried out jointly by designated members of the team. This usually results in a decrease in the numbers of service providers that interact with the child on a daily basis. Other characteristics of the transdisciplinary approach are joint team effort, joint staff development to ensure continuous skill development among members, and role release.

Role release refers to a sharing and exchange of certain roles and responsibilities among team members. It specifically involves sharing of some functions traditionally associated with a specific discipline. For example, the physical therapist may provide training and support to the early childhood teacher to enable her to position a child with physical disabilities. Likewise, the nurse may provide training to all team members to monitor a child's seizure activities. Effective implementation of the role release process requires adequate sharing of information and training. Team members must have a solid foundation in their own discipline combined with a knowledge base that recognizes the roles and competencies of the other disciplines represented on the team.

All team members have unique skills and information they can share with others, therefore role release must occur across all team members.

Activity 4.3

Write your job title, discipline and/or role on a team on a piece of paper. If you are in a group, share it with others. Then throw the piece of paper away. How do you feel? Would it help team development if we could "release" our role?

There are four assumptions that govern the transdisciplinary team model:

1. Natural environments are the best place to assess and develop children's abilities.

2. Children should be taught clusters of skills needed for everyday living. These skills are best taught through natural routines and activities.

3. Discipline-specific goals and objectives should be implemented throughout the day and in all the settings in which the child functions.

4. Skills must be taught and reinforced in the settings in which they naturally occur.

Activity 4.4

List some advantages of the transdisciplinary approach in early intervention that you recognize.

In the transdisciplinary approach, the child's program is primarily implemented by a single person or a few persons with ongoing assistance provided by team members from the various disciplines. This strategy facilitates the delivery of appropriate interventions across developmental domains throughout the child's day, as opposed to having a specific speech therapy session, fine motor occupational therapy session, etc. This does not mean that different interventionists stop providing direct services to children. In reality, in order for early intervention to be effective, all service providers need to maintain direct contact with the child with a disability. The provision of this team model should never be used as a strategy to justify the reduction of staff.

There are a number of factors a transdisciplinary team must consider as it prepares to assign roles and responsibilities, including:

- ***The needs of the child and family.***

  When assigning roles and responsibilities for service delivery, the intervention team's first consideration should be the family's needs and concerns related to the development of the child. The competencies of the individuals selected to implement interventions should fit the child's needs and abilities. When assigning roles, the team should consider carefully the competencies and interests of individual service providers rather than the specific skills associated with a particular discipline.

  For example, a speech pathologist is trained to work effectively with children who have speech and language impairments. However, if the child has other needs that impact his or her speech development, the speech pathologist must also be able to attend to those needs; and, at times, those needs might overlap into a different developmental area, such as motor or cognition. The most important criteria for selecting service providers is that they have an open and trusting relationship with the family, a supportive and integrated team from which to receive guidance, and an interest in providing developmental support and intervention to the child.

- ***The skills and knowledge of individual team members.***

  Service providers should be selected who have the skills needed to address multiple needs. For example, a special educator may be selected as the primary interventionist because he or she can address a particular child's cognitive, social, and language needs. The speech pathologist may serve as a consultant, helping the special educator embed the child's communication goals into daily activities.

- ***The availability of service providers.***

  One of the assumptions of the transdisciplinary model is that children should be taught skills needed for everyday living. These skills are best taught through natural routines and activities. Some service providers, who have the competencies to address a child's needs, may not have the access to the child's natural environments. For example, a physician may be the most familiar and influential service provider for a

family with a child who has medical needs. However, physicians typically work in very specialized and isolated settings. Therefore, an intervention team might select a nurse as the primary person responsible for implementing the intervention program. The physician could consult with the team on how to meet the child's healthcare needs in the home and other community settings. Additionally, the physician may continue to provide direct services by monitoring the child's health and dispensing medical treatment.

Although collaborative transdisciplinary service delivery teams appear simple in concept, implementation of this strategy can be difficult because of the differences between it and the more familiar structured, discipline specific team structures. Barriers to the effective use of this service delivery strategy have been identified as philosophical, professional, interpersonal, and administrative. In particular, the time commitment required to implement a collaborative team model effectively across the necessary disciplines and individuals may be difficult for some early childhood programs. Additionally, many early childhood intervention staff may not have expertise or experience in a collaborative, transdisciplinary team approach, thus diminishing the feasibility of such a strategy.

Team Process

Whether developing an assessment protocol or an IFSP, the common denominator to team effectiveness is the use of a functional process. Unfortunately, many service providers lack the skills necessary to maintain an effective team process. These skills include the ability to overcome barriers, the motivation to accomplish the team's mission and goals, and the perseverance to maintain positive interactions. Five factors that affect the development and maintenance of a team have been identified. It is important for members to be aware of these factors and to understand how they influence team development and maintenance.

Team Composition and Representation

Many factors influence the performance and development of the team. Program or agency affiliation of the members exerts a strong influence on the team process. For example, the resources available to a team depend on the participating programs and/or agencies. These resources can include money, administrative support, and time. Teams with fewer resources need to be more creative in identifying and implementing solutions.

Additionally, a group's size and membership composition will affect collaborative outcomes. Different teams have variations in structure, and all agencies and/or disciplines will not necessarily be represented on every team. The number of personnel and the variety of roles each play may vary dramatically, depending on the needs of the child and his or her family and on the purpose of the team.

Team Goals

Teams must devote time to identifying their goals and objectives. A truly effective team is made up of members who share responsibility for accomplishing common goals. An effective team:

- ***Adopts goals that are clearly understood, and communicated to all team members.***

  A collaborative philosophy or mission is the team's overall reason for existence and it provides the team with a focus for its actions. A written statement of the collaborative philosophy clearly delineates the team's direction. A team functions effectively to the extent that its philosophy is clear and agreed upon by all participants.

Activity 4.5

List the members of the early intervention team on which you currently serve.

_____

_____

_____

_____

_____

- ***Shares ownership of the goals and participates in setting them.***

  All team members (including the family) need to feel that their input is valued. This helps to ensure that the goals are clearly understood by everyone on the team.

- ***Delineates goals that are operationally defined and measurable.***

  Goals must be written in such a way that everyone has a clear understanding of what is expected, and how success will be determined and measured.

- ***Conveys individual or personal objectives with one another.***

  Since teams are comprised of individuals, it is important to respect the human elements of any team.

Activity 4.6

List and describe the goals of the early intervention team to which you belong.

Roles Within the Team

The members of a team are unique individuals who possess different skills, knowledge, and personalities. To be effective, each team member must be assigned a role and clearly understand the identified responsibilities. Ambiguity is a major cause of conflict, therefore team members must continually clarify their current roles, including that of the leader.

In addition to the typical professional roles, responsibilities, and contributions of team members, members will assume other roles with regard to team development, maintenance, and problem solving. These roles, or functions as they are sometimes called, must occur within the group in order for the team to progress effectively.

To facilitate an effective team process, every team member has a responsibility to:

- Prepare family members for their role on the team and encourage their active participation.
- Share their expertise with other team members.
- Offer recommendations for addressing a service or a child's need from his or her own perspective or area of expertise.
- Listen actively and use good communication skills. Be clear and concise when reporting information, and avoid the use of jargon that other team members may not understand.
- Recognize the contributions of other team members, and encourage the sharing of information.

Team Work Style

The team's work style affects the team's development and overall effectiveness. Effective team decisions result from the use of a systematic problem solving process. If that process occurs haphazardly, the team is less likely to make appropriate decisions. The probability of an effective outcome is increased when a formalized, systematic process of problem solving is applied. Systematic problem solving ensures that members are satisfied with, and committed to, team decisions.

Activity 4.7

Describe the problem-solving process your team currently uses.

The literature offers a variety of problem-solving models. One model, PROJECT BRIDGE, recommends a five-step process which serves two functions. In the first function, each step serves as a check point for problem solving. Concurrently, in its second capacity, the process acts as an evaluation tool to compare team ideas and practices to the model of best practices to exemplary services in the field of early childhood education. The steps include:

- ***Problem formulation and information gathering.***

  Describe the problem in clear and observable terms. Identify resources. Throughout, focus on facts, rather than opinions.

- ***Generating proposals for solution.***

  Generate as many alternatives as possible. Withhold judgment and build positively on all suggestions.

- ***Selecting alternatives and testing solutions.***

  Explore the available resources, and evaluate the alternatives in order to attain the best solution. Decide whether or not the solution makes good use of the resources, is cost effective, and fits the needs and goals of the child and family.

- ***Action planning and implementation.***

  Assign specific responsibilities to individuals, determine timelines, and develop procedures to monitor the plan. Communicate the finished document to all relevant personnel.

- ***Monitoring and evaluation.***

  Develop a scheme to judge the success of any decisions. Include in the scheme a unit of evaluation, and how often to evaluate. Modify the plan as needed.

Planned meetings are the hub of the team process. The team must work face-to-face in order to function, and the planned meeting serves as a vehicle for facilitating the completion of the team's tasks and the achievement of its goals. A well-functioning team meets at regularly scheduled times and all team members attend. An effective team meeting begins with a purpose or goal identified in a written agenda, and includes both general team and specific individual charges and problem-solving tasks. Distribute the agenda in advance of the meeting so that team members can prepare for discussion of the issues. Previously established meeting roles (i.e., facilitator, recorder, timekeeper, etc.), and rules (including policies of confidentiality, timeframes for topics, and orders for procedure, etc.) will expedite meeting activity. Keep a written record of the attendees and the meeting business to document recommended actions, to provide follow-up, and to track progress. A well-planned meeting ensures that communication between the team members evolves into a habit.

Activity 4.8

Use the five-step problem-solving process of PROJECT BRIDGE to solve some of the concerns of Polly's parents.

Problem formulation
and information gathering

Generating proposals
for solution

Selecting alternatives
and testing solutions

Action planning
and implementation

Monitoring
and evaluation

Team Leadership

A team is comprised of individuals who are products of their past experiences and, consequently, bring different attitudes, values, and beliefs with them to the team. Individuals also bring expectations about the team: how it should function and what it should accomplish, for example. The personalities of the team members may ultimately determine the team's effectiveness.

Team leaders must adapt their style to meet the diverse needs and styles of the individuals who make up the group. The team leader should foster a climate in which all members feel free to contribute their ideas. In this atmosphere, the members can express differing viewpoints and proposed solutions.

Teams may have formal leaders who are assigned, appointed, or elected by group endorsement. Informal leaders may emerge because of their influence. The team may accept or propel a person into an informal leadership role for a number of reasons: his or her knowledge, skill, personal qualities, or because of the ineffectiveness of the formal leadership. Often, both types of leaders operate simultaneously. This can precipitate problems if the team members ignore the distinctions between informal and formal roles or misappropriate the functions of each. A team leader has a number of roles or functions with regard to a team's development. The main function of the leader is to focus the team on its collective responsibility, which is to ensure that collaborative early intervention services are delivered effectively.

As previously stated, the leadership role within an early intervention service delivery team should be assumed by the service coordinator. The service coordinator has the responsibility for ensuring that the team members put aside their individual agendas in order to focus on the needs of the family and child. The service coordinator will have to facilitate the communication process so that team members develop mutual goals and strategies with the family. Communication is one skill which all team members will have to emphasize to develop an effective and functional team process.

Activity 4.9

Who should be Polly's service coordinator, and how could the team organize her service delivery plan to create a more transdisciplinary model?

Notes

Collaborative service delivery models yield a broad range of benefits. The most important benefit is identified as the improvement in service delivery to children with disabilities and their families. Collaborative efforts enable parents and service providers to efficiently locate and manage the services required by the family. Yet, service providers, as well as the community, gain from the collaborative model with a more efficient and effective use of available resources--manpower, material and money--across agencies.

The mere recognition of the benefits has not resulted in effective collaborations. Today, collaborative early intervention service systems remain an elusive goal for many states. Fragmented and isolated services continue to occur by default, rather than by choice, because professionals have not had the opportunity to learn and practice alternative ways of working together. Communication across disciplines is one such skill that is key to the collaborative process.

The Communication Process

On an average, individuals spend 70% of their waking hours communicating with others. Communication is fundamental to all relationships, and the substantial component of human relationships. Easily taken for granted, good communication between individuals is a complete and intricate process which requires constant attention and consistent application.

Communication is the process of exchanging information between two or more people. It is not only the exchange of information that is important, but the process by which the information is exchanged. The communication process is impacted by circumstance, situation, and context. It is also affected by environment: the physical, social, and emotional conditions. The more complex the task, information, or goals, the more important communication processes are to successful outcomes.

During the process of communication, information can be shared in a *unilateral*, *directive*, or *transactional* manner.

- *Unilateral* communication is one-way, and involves no face-to-face contact. Films, videos, letters, books, and taped lectures are examples of unilateral communication.
- *Directive* communication is face-to-face, but again is only a one-way sharing of information. Examples include lecturing, directing, and explaining.
- *Transactional* communication is face-to-face and two-way. All participants in the interaction are involved in the exchange; all send and receive messages, and all speak and listen. The purpose of transactional communication is to arrive at shared meanings.

Components of Communication

In order for good communication to occur, we need a sender, a message, and a receiver. The sender must be able to formulate the information to be transmitted, and to evaluate the importance of that information to the situation at hand. He or she then converts the message into verbal and nonverbal messages (nonverbal messages are usually unconscious). Finally, he or she sends the message in a way that is appropriate for the receiver in terms of form of expression and amount of information.

The receiver must be able to listen actively, select what is important in the verbal message, and recognize the messages being conveyed nonverbally. The receiver's state of mind and level of comfort will impact one's ability to attend to and receive information. The receiver then interprets the message, either understanding or misunderstanding it. Accurate interpretation is based on self-awareness, a desire to understand, and a willingness to ask for clarification. After asking clarifying questions and gaining all the important information, the receiver can form an opinion and a response. It is difficult not to jump to opinions and conclusions before all the information is clearly understood.

The next step for the receiver is to respond to the message, and to let the speaker know through verbal and nonverbal feedback what was heard and how it was understood and evaluated. In this step, the receiver becomes the sender.

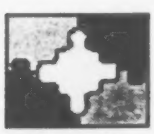
In any spoken message, approximately 7% of the meaning is carried by the words used. Another 38% of the meaning is transmitted through the vocal behavior of the speaker, including the voice quality, intonation, rate of speech, etc. The remaining 55% of meaning is conveyed by nonverbal behaviors. For example, if someone says, "I'm really glad to be here," and the person is standing with eyes downcast, shoulders stooped, brow wrinkled, and arms crossed, we would have a hard time believing that the sender was really glad to be there!

Communication occurs when the right person says the right thing, to the right people, at the right place, at the right time, and in the right way to be heard and understood, and to produce the desired response.

Nido R. Qubein

Activity 5.1

Think of two or three statements or remarks heard in your professional setting that bother you (e.g., "That family will never be able to get their act together!"). What is it that disturbs you about this statement? What does the statement imply to you? Why does that implication bother you? Imagine the possible frames of reference someone who makes such a statement may have. Try to generate four or five different frames.



Communication Strategies

Good communication builds trust because the listener interprets the message exactly as the speaker intended. This means the speaker must be skilled at both verbal and nonverbal message delivery.

Verbal Communication

Words must be clear and understandable. To accomplish this, the early interventionist should:

- ***Clarify words that may have more than one meaning.***

  For example, saying a child's performance is "average", could mean all children the same age as the child are expected to do as well, that 50% of the children his age would be able to do it, or that it is acceptable for the child's age.

- ***Avoid using professional jargon.***

  Parents do need to learn the terminology relating to their own child's disability, but this should be introduced and explained over time. Whenever possible, common words should be used and all abbreviations should be explained.

  For example: When communicating with a parent, an inappropriate statement would be, "At the IFSP meeting, you will get the results of the OT's assessment and we will discuss options for an oral motor stimulation."

A clearer, appropriate statement could be, "We will be meeting to discuss Melissa's feeding needs. Jane Brown, the occupational therapist, will explain what she learned by watching Melissa. We will then be able to discuss how to help Melissa strengthen and coordinate her sucking and swallowing so she can learn to drink from a bottle."

Nonverbal Communication

A lot of communication can be transmitted nonverbally, sometimes unintentionally. Early interventionists should:

- ***Monitor voice tone so it corresponds with the verbal message.***

  Supportive and helpful messages will not be heard if an angry tone of voice is used.

- ***Speak clearly.***

  Be careful not to mumble or use a voice that is too soft or booming.

❖ ***Pace speech.***

Be careful not to talk too quickly or too slowly.

❖ ***Monitor facial expressions to minimize misinterpretations.***

If a person's facial expression appears tired and bored, it may be interpreted to mean indifference or intolerance. If someone's expression is always smiling and happy even when discussing difficult problems, it could be interpreted as superficial, insincere, and unempathetic.

❖ ***Use appropriate eye contact.***

Eye contact indicates interest and attention.

❖ ***Use appropriate gestures.***

Nonverbal communication can deliver the message. Be aware of any distracting or repetitive gestures that you use.

❖ ***Monitor posture.***

Posture can indicate interest. Constant changes of position suggest restlessness and boredom.

Listening Skills

In order to complete a communication interchange that is helpful and productive, early interventionists should also be able to demonstrate effective listening skills with parents. To communicate interest in, and acknowledgment of, what is being said, early interventionists should:

❖ ***Use open-ended questions to clarify information.***

Close-ended questions (answered by one word or yes/no) should be avoided except to clarify a point. For example:

Open-ended:
How do you think Billy's development will be affected by his cerebral palsy?

Close-ended:
Do you understand how Billy's development will be affected by his cerebral palsy?

❖ ***Use subtle encouragers.***

Head nods, "umhmms," smiles or other facial expressions, and comments such as "Tell me more" can be used to indicate interest and a desire to hear more.

- ***Listen, and do not talk too much.***

  Interruptions, unsolicited advice, and comments that do not relate to the topic indicate a lack of interest in what is being said and may be interpreted as being critical. This may discourage parents from saying more.

- ***Clarify any words, time frames, or expressions that may be misinterpreted.***

  For example, if a father says his son has been hyperactive since he was a baby, ask him to give you some examples of the son's hyperactivity. Also, clarify the child's age. In their family, does "baby" mean infancy, toddler period, or an age older than age two?

- ***Repeat back what was heard.***

  By simply repeating the information given by the parent, acknowledgment and acceptance is communicated.

- ***Reflect the parents' feelings.***

  Reflecting feelings is more difficult than repeating facts, but it is a critical part of effective listening.

- ***Paraphrase and summarize comments.***

  It is important to periodically review what has been said. This step assures the parents that the content, sequence, and facts have been heard correctly. It is particularly important to do this at the end of the meeting or conversation.

Active listening is a skill that can be developed to improve the listener's ability to hear and interpret the message accurately. The active listener provides feedback to the speaker about what the listener is understanding, thereby allowing the speaker to agree that what was understood is what was intended, or, if not, to clarify the speaker's intention. Active listening communicates respect, understanding, empathy, and acceptance.

People can often solve their own problems if given the chance.

Activity 5.2

For this activity, choose a partner. Decide who will be the message sender and who will be the message receiver. The message sender should paraphrase the situation facing Polly's family. The receiver should take notes on the verbal and nonverbal messages that facilitate and inhibit the communication process.

Facilitators _____

_____

_____

_____

_____

_____

Inhibitors _____

_____

_____

_____

_____

_____

Barriers to Communication

Communication always contains an element of risk, thereby inhibiting the exchange of information. Often a dilemma exists between an individual's need to communicate and be heard and fear of rejection, failure, or ridicule. People may deal with their fears by keeping silent, censoring what they say, pretending to agree, or phrasing their thoughts in vague or ambiguous ways. All of these behaviors interfere with the communication process. On teams, the amount of risk is compounded by the number of people present. Sometimes people assume there is no need to talk ("If it isn't broken, don't fix it"), or that there is no need to listen ("She's talking to the PT; it really doesn't concern me"), or they assume there is no need to respond.

One-way communication, as in lecturing or telling someone how something should be, can also inhibit communication by sending mixed messages.

Vocal expressions that block effective communication include speaking in a loud and fast voice, and using high or aggressive tones, and using infrequent pauses.

On the receiver's end, a noisy or distracting environment, daydreams, simultaneous thoughts about a response to the speaker's message, and emotional distraction are the four elements most likely to prevent the listener from accurately receiving the message. People need to take responsibility for their communication by minimizing distractions when possible, or postponing communication until a later time when the distractions will not be a factor. Listeners need to pull themselves back from the tendency to daydream, and make an effort to concentrate on the speaker. Sometimes stopping to take a break, taking notes, asking questions, or simply shifting one's body position can help. The listener needs to let the speaker complete the message before considering a response.

Often it is difficult for us to listen for a number of reasons. We are not taught to listen, but rather to express our own thoughts and opinions. Assertive communication is rewarded in many arenas, and sometimes people are so busy talking that they are unable to listen. Many times we prejudge the speaker, and our preconceived notions make it difficult for us to take the person seriously or to really listen to what he or she has to say. It is important for us to learn to be aware and respectful of diverse interests, opinions, and values, including those that may be very different from our own.

Activity 5.3

Choose someone to tell a story to about "my first day at my current job" or "why I became an early interventionist." Then ask the listener to repeat back to you the story as they heard it. Both of you then fill out the following checklist on your communication skills: evaluating them as you were telling the story (presenting) and hearing it back (receiving).

Effective Communication Self Review

PRESENTING INFORMATION	YES	NO
Verbal Messages: While presenting information to the listener I clarified the meaning of any word that could have more than one meaning.		
I avoided professional jargon.		
Nonverbal Messages: I tried to be aware of my tone of voice and kept it consistent with the verbal message.		
I spoke clearly at all times.		
I paced my speech at all times.		
Body language: I tried to keep my facial expression consistent with the verbal message.		
I used eye contact when appropriate.		
I remained aware of my use of gestures, posture, and position at all times.		

RECEIVING INFORMATION		
To communicate interest: I used open-ended questions instead of close-ended whenever possible.		
I did little talking and more listening.		
To communicate understanding: I asked for clarification on points that were unclear.		
I reflected facts and feelings back to the speaker.		
I paraphrased and summarized the speaker's comments.		

Trust Building

Communication is facilitated when the people communicating: 1) trust one another; 2) feel confident that they share the same goals; 3) work together in the service of families; and, 4) deal openly with any disputes that may arise. When this occurs, people feel comfortable asking questions, clarifying information, providing honest feedback, challenging assumptions, admitting that they do not have all the answers, and deciding together on the best course of action. When people are comfortable with each other, there is tacit permission to disagree, ask questions, and not have all the answers. Each member of the group feels respected, listened to, and valued.

The development of trust is a slow process. Someone takes a risk by disclosing some small thing; the team is supportive, the climate is comfortable, and people learn that it is okay to take risks. Gradually, the risks become larger, as people become more secure in their belief that they will be supported and respected by the other team members.

This kind of open communication fosters effective problem solving, demonstrates empathy and acceptance, minimizes misunderstandings, and helps each team member gain insight into the values, experiences, and attitudes of others.

Negotiation and Conflict Resolution Skills

During the collaborative process, communication may result in conflict. Conflict is any situation in which one person or group perceives that another person or group is interfering with his or her goal attainment. Conflict is a natural part of human interaction and should not be feared, but rather, managed. It is possible for disputing parties to have all of their needs met in a win/win resolution.

People tend to approach conflict in a variety of ways. There are five common styles of conflict management, each of which presents benefits and drawbacks. The style of conflict management used in a situation often depends on the content and context of the issue.

One style of conflict management is the ***competitive*** style. This style is characteristic of people who tend to overpower others with whom they have a conflict. Their goal is to win, regardless of possible negative

consequences. This may be an appropriate style to utilize when there are ethical concerns or when one is certain of being right. However, some pitfalls of the competitive style are that others may stop engaging in meaningful interactions and collaborative relations can be seriously inhibited or destroyed.

Avoidance, a second style of conflict management, occurs when people try to avoid conflict by ignoring discrepancies between their own goals and those of others. When conflict is emotionally laden and people need time to regain their composure, avoidance may be a very appropriate and sensitive method for handling conflict. However, this approach can give a false sense that all is well. By not addressing the issue directly, conflict can continue to plague the group and may escalate as the result of inaction.

People who put aside their own needs in order to ensure that others' needs are met are engaging in an ***accommodating*** style of conflict management. Accommodating is appropriate when the conflict is relatively unimportant or when you are unable to alter an adversarial situation. The negative ramifications, however, can prove very frustrating. Frequent accommodation may result in others devaluing your ideas over time and may cause you to feel that others are taking advantage of you.

A less surrendering style of conflict management is ***compromising***. In the compromising style, people make concessions on an issue while asking others to do the same. This can be a very useful approach when the discussion has reached a deadlock. Although a benefit of this style is that the end result is usually acceptable to all, compromising falls short of meeting the needs of all.

Certainly the most desirable style of conflict management is ***collaborative*** problem solving. In this style, people utilize a high degree of both assertion and cooperation. Although the collaborative style tends to be time-consuming and requires a trusting rapport among professionals, the benefits provided bring new and creative solutions to problems. The collaborative process requires that all members clarify the issues and commonly determine the goals. This shared commitment to collaboration results in less conflict and greater satisfaction for those involved.

Activity 5.4

Use the following questionnaire to see what strategies you use to manage conflict.

THOMAS-KILMANN CONFLICT MODE INSTRUMENT*

Consider situations in which you find your wishes differing from those of another person. How do you usually respond to such situations? Following are several pairs of statements describing possible behavioral responses. For each pair, please circle the "A" or "B" statement that is most characteristic of your own behavior. In many cases, neither the "A" nor the "B" statement may be very typical of your behavior; but please select the response that you would be more likely to use.

1. A. There are times when I let others take responsibility for solving the problem.
   B. Rather than negotiate the things on which we disagree, I try to stress those things upon which we both agree.
2. A. I try to find a compromise solution.
   B. I attempt to deal with all of his/her and my concerns.
3. A. I am usually firm in pursuing my goals.
   B. I might try to soothe the other's feelings and preserve our relationship.
4. A. I try to find a compromise solution.
   B. I sometimes sacrifice my own wishes for the wishes of the other person.
5. A. I consistently seek the other's help in working out a solution.
   B. I try to do what is necessary to avoid useless tensions.
6. A. I try to avoid creating unpleasantness for myself.
   B. I try to win my position.
7. A. I try to postpone the issue until I have had some time to think it over.
   B. I give up some points in exchange for others.
8. A. I am usually firm in pursuing my goals.
   B. I attempt to get all concerns and issues immediately out in the open.
9. A. I feel that differences are not always worth worrying about.
   B. I make some effort to get my way.
10. A. I am firm in pursuing my goals.
    B. I try to find a compromise solution.

*Thomas/Kilmann, *Thomas-Kilmann Conflict Mode Instrument*, Copyright 1974, Xicom, Inc., Tuxedo, New York.

11. A. I attempt to get all concerns and issues immediately out in the open.
    B. I might try to soothe the other's feelings and preserve our relationship.
12. A. I sometimes avoid taking positions which would create controversy.
    B. I will let the other person have some of his/her positions if he/she lets me have some of mine.
13. A. I propose a middle ground.
    B. I press to get my points made.
14. A. I tell the other person my ideas to ask for his/hers.
    B. I try to show the other person the logic and benefits of my position.
15. A. I might try to soothe the other's feelings and preserve our relationship.
    B. I try to do what is necessary to avoid tensions.
16. A. I try not to hurt the other's feelings.
    B. I try to convince the other person of the merits of my position.
17. A. I am usually firm in pursuing my goals.
    B. I try to do what is necessary to avoid useless tensions.
18. A. If it makes other people happy, I might let them maintain their views.
    B. I will let other people have some of their positions if they let me have some of mine.
19. A. I attempt to get all concerns and issues immediately out in the open.
    B. I try to postpone the issue until I have had some time to think it over.
20. A. I attempt to immediately work through our differences.
    B. I try to find a fair combination of gains and losses for both of us.
21. A. In approaching negotiations, I try to be considerate of the other person's wishes.
    B. I always lean toward a direct discussion of the problem.
22. A. I try to find a position that is intermediate between his/hers and mine.
    B. I assert my wishes.
23. A. I am very often concerned with satisfying all our wishes.
    B. There are times when I let others take responsibility for solving the problem.
24. A. If the other's position seems very important to him/her, I would try to meet his/her wishes.
    B. I try to get the other person to settle for a compromise.
25. A. I try to show the other person the logic and benefits of my position.
    B. In approaching negotiations, I try to be considerate of the other person's wishes.
26. A. I propose a middle ground.
    B. I am nearly always concerned with satisfying all our wishes.
27. A. I sometimes avoid taking positions that would create controversy.
    B. If it makes other people happy, I might let them maintain their views.
28. A. I am usually firm in pursuing my goals.
    B. I usually seek the other's help in working out a solution.
29. A. I propose a middle ground.
    B. I feel that differences are not always worth worrying about.
30. A. I try not to hurt the other's feelings.
    B. I always share the problem with the other person so that we can work it out.

Scoring the Thomas-Kilmann Conflict Mode Instrument

Circle the letters below which you circled on each item of the questionnaire.

	Competing (forcing)	Collaborating (problem solving)	Compromising (sharing)	Avoiding (withdrawal)	Accommodating
1.				A	B
2.		B	A		
3.	A				B
4.			A		B
5.		A		B	
6.	B			A	
7.			B	A	
8.	A	B			
9.	B			A	
10.	A		B		
11.		A			B
12.			B	A	
13.	B		A		
14.	B	A			
15.				B	A
16.	B				A
17.	A			B	
18.			B		A
19.		A		B	
20.		A	B		
21.		B			A
22.	B		A		
23.		A		B	
24.			B		A
25.	A				B
26.		B	A		
27.				A	B
28.	A	B			
29.			A	B	
30.		B			A
Total number of items circled in each column					
	Competing	Collaborating	Compromising	Avoiding	Accommodating

In which column did you receive the highest score?_____

Methods for Resolving Conflict

Resolution of conflicting goals, philosophies, and objectives is the foundation for building collaborative relationships. By following prescribed steps to achieve collaboration, shared commitment and responsibility are the natural byproducts that result from the process. The steps involved require members of interagency teams to share not only their knowledge and expertise, but also their expectations. When entering into interagency collaborations, it is effective to have some agreed upon guidelines that will be followed when conflicts arise. These guidelines should designate the steps the group will take to resolve conflict and the process by which any negotiation of ideas will be conducted.

Separate the People From the Issues

Because people feel strongly about their positions in a conflict, egos become entangled with the issues. Team members need to see themselves as working side by side to attack a mutual problem, rather than each other.

Focus on Interests, Not Positions

Often in a conflict situation, people state their positions, then become determined and argue for that position. In fact, there are underlying interests which are obscured by positions and may never get addressed, if positions are the basis for the discussion. For example, one team member may argue that the team should set a regular meeting schedule, while another may want to set meeting dates as the need to meet arises. There appears to be no easy solution to this conflict.

If we look beyond the positions to the interests, we may find that the first person needs to arrange childcare for her child in order to come to team meetings, and her childcare person needs advance notice. The second person may be pressured by his or her supervisor to spend more time in the office catching up on paperwork. A solution may be to set tentative meeting dates on a regular basis, with the understanding that some may be canceled if they are not needed. Active listening is a powerful tool to let the other side know that you have heard and understood their interests.

Invent Options for Mutual Gain

Setting aside a designated time to brainstorm a number of possible options decreases the urge to make a decision quickly; it also opens the door for new, creative solutions that may not surface if people take an adversarial stance and argue just to win their position.

Insist that the Result Be Based on Some Objective Standard

Rather than bending to someone's will, find some objective way of deciding an issue, or of testing the decision. For example, if two team members disagree on how often a child should be seen for therapy, they may decide to research the literature to see what experience has been suggested to be the optimal number of hours/week for a child of that age and ability to be seen.

Conflict often can be avoided or quickly diffused by adhering to a defined process. First, all members should participate in clarifying the issues. Once the issues have been defined, the expectations and outcomes should be set and agreed upon by everyone involved. This requires clear and open communication. When conflicting attitudes exist, strategies can be used to stimulate new alternatives and options. Among these strategies are: 1) problem solving; 2) brainstorming new options; 3) selecting from among new options; and, if consensus cannot be attained, 4) engaging in negotiations.

Negotiations

Effective negotiations can generate amenable solutions to conflicts. However, to keep negotiations productive and on track, the following activities must occur:

- Suggest new options and alternatives that would prove mutually beneficial.
- Carefully control anger and resistance so that the process is not hindered further.
- Be sure to use objective criteria for making decisions and achieving consensus.
- Use newly offered alternatives to find a solution that may be commonly agreed upon and accepted.

Activity 5.5

Fill out the following questionnaire to evaluate your negotiation skills

How Well Do You Negotiate?*
A Self-Evaluation

Please circle the most appropriate answer.

1. Do you generally go into negotiations well prepared?
   (a) Very frequently
   (b) Often
   (c) Sometimes
   (d) Not very often
   (e) Play it by ear

2. How uncomfortable do you feel when facing direct conflict?
   (a) Very uncomfortable
   (b) Quite uncomfortable
   (c) Don't like it but face it
   (d) Enjoy the challenge somewhat
   (e) Welcome the opportunity

3. How do you look at negotiation?
   (a) Highly competitive
   (b) Mostly competitive but a good part cooperative
   (c) Mostly cooperative but a good part competitive
   (d) Very cooperative
   (e) About half cooperative and competitive

4. What kind of deal do you go for?
   (a) A good deal for both parties
   (b) A better deal for you
   (c) A better deal for him
   (d) A very good deal for you and better than no deal for him
   (e) Every person for themselves

5. Do you like to negotiate with merchants (furniture, cars, major appliances)?
   (a) Love it
   (b) Like it
   (c) Neither like nor dislike it
   (d) Rather dislike it
   (e) Hate it

6. Are you a good listener?
   (a) Very good
   (b) Better than most
   (c) Average
   (d) Below average
   (e) Poor listener

*Karrass, Chester, L. (1989). *Effective negotiating.* Santa Monica, CA: Karrass.

7. How do you feel about ambiguous situations--situations which have a good many pros and cons?
   (a) Very uncomfortable. Like things one way or another.
   (b) Fairly uncomfortable.
   (c) Don't like it but can live with it.
   (d) Undisturbed. Find it easy to live with.
   (e) Like it that way. Things are hardly ever one way or another.

8. How would you feel about negotiating a 10% raise with your boss if the average raise in the department is 5%?
   (a) Don't like it at all. Would avoid it.
   (b) Don't like it but would make a pass at it reluctantly.
   (c) Would do it with little apprehension.
   (d) Make a good case and not afraid to try it.
   (e) Enjoy the experience and look forward to it.

9. How good is your business judgment?
   (a) Experience shows that it's very good
   (b) Good
   (c) As good as most other executives
   (d) Not too good
   (e) I hate to say it, but I guess I'm not quite with it when it comes to business matters.

10. When you have the power, do you use it?
   (a) I use it to the extent I can
   (b) I use it moderately without any guilt feelings
   (c) I use it on behalf of fairness as I see fairness
   (d) I don't like to use it
   (e) I take it easy on the other fellow

11. How do you feel about getting personally involved with the other party?
   (a) I avoid it
   (b) I'm not quite comfortable
   (c) Not bad--not good
   (d) I'm attracted to getting close
   (e) I go out of my way to get close. I like it that way

12. How sensitive are you to the personal issues facing the opponent in negotiation? (The non-business issues like job security, workload, vacation, getting along with the boss, not rocking the boat.)
   (a) Very sensitive
   (b) Quite sensitive
   (c) Moderately
   (d) Not too sensitive
   (e) Hardly sensitive at all

13. How committed are you to the opponent's satisfaction?
    (a) Very committed. I try to see that he doesn't get hurt
    (b) Somewhat committed
    (c) Neutral but I hope he doesn't get hurt
    (d) I'm a bit concerned
    (e) It's everyone for themselves

14. Do you carefully study the limits of the other person's power?
    (a) Very much so
    (b) Quite a bit
    (c) I weigh it
    (d) It's hard to do because I'm not him
    (e) I let things develop at the session

15. How do you feel about making a very low offer when you buy?
    (a) Terrible
    (b) Not too good but I do it sometimes
    (c) I do it only occasionally
    (d) It's hard to do
    (e) I make it a regular practice and feel quite comfortable

16. How do you usually give in?
    (a) Very slowly, if at all
    (b) Moderately slowly
    (c) About at the same pace he does
    (d) I try to move it along a little faster by giving more
    (e) I don't mind giving in hefty chunks and getting to the point

17. How do you feel about taking risks that affect your career?
    (a) Take considerably larger risks than most people
    (b) Somewhat more risk than most
    (c) Somewhat less risk than most
    (d) Take slight risk on occasion but not much
    (e) Rarely take career risks

18. How do you feel with those of higher status?
    (a) Very comfortable
    (b) Quite comfortable
    (c) Mixed feelings
    (d) Somewhat uncomfortable
    (e) Very uncomfortable

19. How well did you prepare for the negotiation of the last house or car you bought?
    (a) Thoroughly
    (b) Quite well
    (c) Moderately
    (d) Not well
    (e) Played it by ear

20. How well do you think when **not** under pressure (compared to your peers)?
    (a) Very well
    (b) Better than most
    (c) Average
    (d) A little worse than most
    (e) Not too good

21. How would you feel if you had to say, "I don't understand that", four times after four explanations?
    (a) Terrible–wouldn't do it
    (b) Quite embarrassed
    (c) Would feel awkward
    (d) Would do it without feeling too badly
    (e) Wouldn't hesitate

22. How well do you handle tough questions in negotiations?
    (a) Very well
    (b) Above average
    (c) Average
    (d) Below average
    (e) Poorly

23. Do you ask probing questions?
    (a) Very good at it
    (b) Quite good
    (c) Average
    (d) Not very good
    (e) Pretty bad at it

24. Are you close-mouthed about your business?
    (a) Very secretive
    (b) Quite secretive
    (c) Secretive
    (d) Tend to say more than I should
    (e) Talk too much

25. How confident are you about your knowledge in your own field or profession (compared to your peers)?
    (a) Much more confident than most
    (b) Somewhat more confident
    (c) Average
    (d) Somewhat less confident
    (e) Not very confident, frankly

26. You are the buyer of some construction services. The design is changed because your spouse wants something different. The contractor now asks for more money for the change. You need him badly because he's well into the job. How do you feel about negotiating the added price?
    (a) Jump in with both feet
    (b) Ready to work it out but not anxious to
    (c) Don't like it but will do it
    (d) Dislike it very much
    (e) Hate the confrontation

INSTRUCTIONS

To evaluate yourself, check the answer key and add your positive and negative scores separately. Subtract them from each other.

A score between +250 and +340 indicates you are probably negotiating well already. The range of +180 to +250 suggests you have a good measure of the qualities it takes to negotiate successfully. Negative scores, however, show that your skills needed for effective negotiating can use improvement!

ANSWER KEY

1.	(a) + 20	(b) + 15	(c) + 5	(d) - 10	(e) - 20
2.	(a) - 10	(b) - 5	(c) + 10	(d) + 10	(e) - 5
3.	(a) - 15	(b) + 15	(c) + 10	(d) - 15	(e) + 5
4.	(a) + 10	(b) + 5	(c) - 10	(d) + 10	(e) - 5
5.	(a) + 3	(b) + 6	(c) + 6	(d) - 3	(e) - 5
6.	(a) + 15	(b) + 10	(c) 0	(d) - 10	(e) - 15
7.	(a) - 10	(b) - 5	(c) + 5	(d) + 10	(e) + 10
8.	(a) - 10	(b) + 5	(c) + 10	(d) + 13	(e) + 10
9.	(a) + 20	(b) + 15	(c) + 5	(d) - 10	(e) - 20
10.	(a) + 5	(b) + 15	(c) + 10	(d) - 5	(e) 0
11.	(a) - 15	(b) - 10	(c) 0	(d) + 10	(e) + 15
12.	(a) + 16	(b) + 12	(c) + 4	(d) - 5	(e) - 15
13.	(a) + 12	(b) + 6	(c) 0	(d) - 2	(e) - 10
14.	(a) + 15	(b) + 10	(c) + 5	(d) - 5	(e) - 10
15.	(a) - 10	(b) - 5	(c) + 5	(d) + 15	(e) + 15
16.	(a) + 15	(b) + 10	(c) - 3	(d) - 10	(e) - 15
17.	(a) + 5	(b) + 10	(c) 0	(d) - 3	(e) - 10
18.	(a) + 10	(b) + 8	(c) + 3	(d) - 3	(e) - 10
19.	(a) + 15	(b) + 10	(c) + 5	(d) - 5	(e) - 15
20.	(a) + 15	(b) + 10	(c) + 5	(d) 0	(e) - 5
21.	(a) - 8	(b) - 3	(c) + 3	(d) + 8	(e) + 12
22.	(a) + 10	(b) + 8	(c) + 2	(d) - 3	(e) - 10
23.	(a) + 10	(b) + 8	(c) + 3	(d) 0	(e) - 5
24.	(a) + 10	(b) + 10	(c) + 8	(d) - 8	(e) - 15
25.	(a) + 12	(b) + 8	(c) + 4	(d) - 5	(e) - 10
26.	(a) + 15	(b) + 10	(c) 0	(d) - 10	(e) - 15

Stages in the Negotiating Process

The negotiation process can be broken into three stages:

Analysis

In this stage, you are trying to diagnose the situation--to gather information, identify your own interests and those of the other side, note options already on the table, and identify any criteria available as a basis for agreement.

Planning

In this stage, you deal again with the same four elements: generating ideas, thinking about how to handle the "people issues" (hostility, unclear communications, biased perceptions, etc.), prioritizing your own interests, and generating some additional options and criteria for evaluating them.

Discussion

Here the parties talk together, working towards agreement, and the same four elements are the best subjects to discuss. It is important to acknowledge each person's feelings of frustration and anger and difficulties in communication, and to thoroughly understand each other's interests. Acknowledgment and understanding puts everybody in a good position to generate options jointly that will benefit everyone, and to reach agreement on objective standards for resolving opposing interests.

The use of these methods will result in a wise and amicable agreement, efficiently reached.

You cannot solve a problem from within the same consciousness that created that problem... you must think anew.

Einstein

Activity 5.6

Get into groups of four. Using the stages of Negotiation Process (analysis, planning, and discussion), describe some possible solutions to the problems Polly's parents have with their current service delivery program. One person on the team will play the role of Polly's parents, the other three will play the roles of the case managers from the three different agencies.

Analysis:

Planning:

Discussion:

Notes